



**SCHOOL OF PSYCHOLOGY - DOCTORATE IN CLINICAL PSYCHOLOGY**

**MAJOR RESEARCH PROJECT**

**LITERATURE REVIEW: Posttraumatic Stress Disorder, Disclosure Ability  
and Masculine Norms in Adult Male Survivors of Child Sexual Abuse:  
A Systematic Review**

**EMPIRICAL PAPER: The Associations between Posttraumatic Stress  
Disorder, Disclosure Ability and Gender Role Perceptions in Adult  
Survivors of Child Sexual Abuse**

Submitted by **Agata Sawicka**, to the University of Exeter as a thesis for the  
degree of **Doctorate in Clinical Psychology**, April 2016

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**SCHOOL OF PSYCHOLOGY – DOCTORATE IN CLINICAL PSYCHOLOGY**

**LITERATURE REVIEW**

**Posttraumatic Stress Disorder, Disclosure Ability and Masculine Norms in  
Adult Male Survivors of Child Sexual Abuse:  
A Systematic Literature Review**

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### **Abstract**

Child sexual abuse (CSA) has been linked to a number of long-term consequences for mental health (MH), including posttraumatic stress disorder (PTSD). This review aims to examine the existing literature for evidence that avoidance of CSA disclosure and stereotypical masculine norms are associated with more severe PTSD symptoms in male survivors.

A number of databases were searched using specific key words and studies identified were assessed for eligibility based on PICOS criteria.

Six correlational quantitative studies and seven qualitative studies that utilised different methodologies were identified in the review. The findings of the quantitative studies were mixed, half suggesting more severe posttraumatic stress symptoms in men who avoided disclosure. Qualitative studies identified barriers to disclosure and impact on masculinity in male CSA survivors.

The evidence suggests that men may suffer from more debilitating symptoms of PTSD and seek help less often than women due to delaying disclosure and barriers associated with more stereotypical masculine norms. Firm conclusions could not be drawn due to the differing methodologies used and the small number of studies that explored all factors. It is therefore important to develop a clearer understanding of this area.

**Keywords:** CSA, PTSD, men, disclosure avoidance, masculine norms



## Introduction

This review explores the associations between disclosure ability and masculine norms with posttraumatic stress disorder (PTSD) symptoms in adult male survivors of child sexual abuse (CSA). CSA has been linked to a number of negative outcomes for survivors in adulthood, including higher PTSD levels (Rowan, Foy, Rodriguez, & Ryan, 1994). The discrepancy between prevalence rates of men who endure CSA and those who seek help suggests that men often suffer psychological distress in silence (Hopton & Huta, 2013). Barriers to disclosure need to be further explored in order to facilitate men's access to evidence-based treatments following traumatic experiences.

CSA is the unwanted experience of single or multiple incidents, which may include contact and non-contact sexual acts prior to the age of 18 (Dube et al., 2005). PTSD is a common consequence of CSA (Briere & Elliott, 2003; Cutajar et al., 2010; Fergusson, Boden, & Horwood, 2008). Rowan et al. (1994) found that 69% of their adult sample of CSA survivors met the criteria for PTSD; of these, 91% were female, which is inconsistent with prevalence rates of CSA (16% for males and 27% for women; Rowan et al., 1994). There is evidence of both reduced disclosure (Ullman & Filipas, 2005) and more stereotypical masculine norms (Banyard, Williams, & Siegel, 2004; Lisak, 1994) among men with CSA history and limited research has pointed to a possible association between the two factors (Banyard et al., 2004; Easton, 2013). If men disclose less often and feel prevented from doing so by more stereotypical norms governing their perception of what it means to be a man, they may experience higher levels of PTSD.

The act of disclosure, understood as both sharing with someone close and telling an authoritative body, has been shown to be beneficial for psychological

functioning in survivors of CSA (Alaggia, 2005; Everill & Waller, 1994) and has been linked to reduced PTSD symptom severity (Ullman & Filipas, 2005). Several theoretical frameworks, including recovery- and healing-based theories, have identified disclosure as an important interpersonal process and a critical component of recovery from CSA (Chouliara, Karatzias, & Gullone, 2013; Burke Draucker et al., 2011; Easton, 2013; Harvey, Orbuch, & Webber, 1990). Disclosure has demonstrated positive therapeutic effects on recovery (Tener & Murphy, 2015), although some studies have found evidence of mixed impact (Mueller, Moergeli, & Maercker, 2008). It has also been reported that most CSA survivors delay disclosure until adulthood, which has been linked to worse mental health outcomes in male survivors within a non-clinical sample (Alaggia, 2005; Easton, 2013). The failure to disclose, to seek help, and thus access evidence-based therapies may mean higher levels of PTSD symptoms among male survivors of CSA.

The other factor directly impacting disclosure ability, which may trap male CSA survivors in the maintenance cycle of PTSD, is the specific impact of masculine norms internalised through socialisation. Gender role socialisation theory points out that women are socialised to ask for help whereas men are taught to remain strong and not to show any weakness (Banyard et al., 2004). Qualitative studies (Banyard et al., 2004; Kia-Keating, Grossman, Sorsoli, & Epstein, 2005; Lisak, 1994) have reported themes related to the questioning of masculinity. No similar studies reporting difficulties with feminine identity or womanhood were identified in the literature search. Previous research has suggested that most perpetrators of CSA are men (Easton, 2013); men are thus more likely to experience abuse at the hands of someone of the same sex. According to Banyard et al. (2004), on one hand, the experience of sexual abuse

by a male perpetrator models traditional masculine culture, especially physical aggression and dominance in sexual relations, but, on the other, confronts male survivors with a conflict of identity for men as they are expected to remain strong and dominant and often keep secret shameful episodes of humiliation. Thus, sexual abuse often results in long-term effects on the male victim's perception of gender and sexual roles; male CSA victims have reported questioning who they are as human and sexual beings and what masculinity means for them (Banyard et al., 2004; Lisak, 1994). A study in which resilient male survivors were interviewed, recovery was attributed to reframing these traditional masculine roles (Kia-Keating et al., 2005). Exploration of potential barriers may be crucial to enabling men to access evidence-based treatments such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). The associations between disclosure, masculine norms and their impact on PTSD symptoms in male survivors of CSA have not been reviewed systematically, and warrant further exploration.

## **Objectives**

This review aims to present a systematic examination of existing evidence on the associations between disclosure avoidance, masculine norms and PTSD in adult male survivors of CSA. It was necessary to formulate the following separate research questions bearing in mind the nature of quantitative and qualitative studies and their different methodologies:

1. Are more severe PTSD symptoms in male survivors of CSA associated with disclosure avoidance or more stereotypical masculine gender norms (quantitative studies)?

2. What are the disclosure experiences of male survivors of child sexual abuse (qualitative studies)?

## **Methods**

### **Eligibility Criteria**

This review sought studies that focused on investigating the relationships between disclosure avoidance, masculine norms and PTSD symptom severity in adult male survivors of CSA. Inclusion criteria were defined in relation to participants, interventions, comparisons, outcomes and study design (PICOS):

#### **Participants**

Must be over the age of 18. Only papers whose sample is at least partially male were included.

#### **Interventions**

No types of intervention were excluded, although studies focusing on evaluating the efficacy of interventions were not of interest in this review.

#### **Comparison**

No comparison groups were required for this review.

#### **Outcomes**

Preliminary searches revealed very few studies measuring all the factors investigated in this review. Studies focusing on two of the factors were included (such as associations between PTSD and disclosure, between PTSD and masculine norms or between disclosure and masculine norms). Studies that measured CSA experiences using formal tools as well as qualitative questions exploring the presence of contact or non-contact sexual abuse experiences prior to the age of 18 were included. Due to the small number of articles on this topic,

broad inclusion criteria had to be defined in terms of psychometric tools used as outcome measures. The review screened for studies measuring PTSD symptoms using structured clinical interviews, such as Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I) or the Clinician Administered PTSD Scale (CAPS-5). SCID-I is a validated instrument that allows the establishment of a PTSD diagnosis based on DSM-IV criteria (Ventura, Liberman, Green, Shaner, & Mintz, 1998). CAPS-5 is based on the new DSM-5 criteria (Weathers et al., 2013). These measures are the most reliable for establishing PTSD diagnoses. The review also screened for studies that utilised validated, self-report measures such as the Impact of Events Scale Revised (IES-R; Weiss & Marmar, 1997), the Foa PTSD Inventory (Foa, Cashman, Jaycox & Perry, 1997) and the Post-Traumatic Checklist-Civilian Version (PCL-C; Weathers, Litz, Herman, Huska & Keane, 1993). Validated, but not rooted in the PTSD criteria of DSM-5 or ICD-10 instruments were also considered for inclusion. Studies that used qualitative questions exploring posttraumatic stress-type symptoms were included. Also, studies that did not measure PTSD directly using structured clinical interviews or the self-report measures described above were included; this applied to measures focusing on mental health symptoms, which included those relevant to PTSD subscales such as experiential avoidance, hyperarousal and dissociation. In the absence of studies using standardised tools to measure disclosure, such as the Disclosure of Trauma Questionnaire (DTQ; Mueller et al., 2008), studies that explored this phenomenon using qualitative questions were included. Studies which operationalised disclosure as seeking help for trauma symptoms following CSA experiences were also included. Quantitative studies that focused on the exploration of masculine norms usually used self-report questionnaires such as the Conformity to Masculine Norms Inventory, (CMNI-22; Mahalik, Burns

& Syzdek, 2003), but those that explored disclosure and masculine gender norms with qualitative interview questions were also included.

### **Study Design**

Due to the limited number of articles available on this topic, no study designs were excluded from this review. Both quantitative and qualitative studies were appraised.

### **Exclusion Criteria**

Studies on children and those involving female-only adult samples were not included in this review. Children and adolescents under the age of 18 would have been reliant on others for disclosure and help seeking; such studies are thus less likely to involve exploration of the factors relevant to this review. The themes of masculine norms explored in relation to adolescent boys, whose masculine identity is only starting to form, are expected to be different. Studies carried out with the military samples were excluded as they explored combat trauma sustained in adulthood. At times these studies focused on participants with both childhood and combat trauma experiences. These were also excluded as it would have made distinguishing the impact of past versus present traumatic experiences difficult. Studies exploring other factors impacting on men following CSA experiences were excluded. Theoretical studies and other literature reviews were also excluded.

### **Information Sources**

The databases searched were Web of Science, Pubmed, EBSCO and Science Direct. The literature search was carried out between September 2015 and January 2016.

## Search Strategy

The search strategy consisted of evaluating of peer-reviewed articles published in English up to January 2016. Their reference lists were screened to identify other studies that met the inclusion criteria. Reference lists of meta-analyses and other literature reviews were also screened for additional studies that met the inclusion criteria.

## Search Terms

The following search terms were entered in all the databases. All searches included a variety of combinations of the proposed search terms.

Table 1

*Search Terms Entered into Databases*

<b>Search Terms</b>	PTSD OR post-traumatic stress disorder OR trauma	CSA OR child sexual abuse	Disclosure OR disclosure ability OR disclosure avoidance	Masculine norms OR gender norms OR gender role perceptions OR masculinity	Men OR males
<b>Search Terms Combined</b>	(PTSD OR “post-traumatic stress disorder” OR “trauma”) AND (CSA OR “child sexual abuse”) AND (“disclosure” OR “disclosure ability” OR “disclosure avoidance”) AND (“masculine norms” OR gender norms” OR “gender” OR “gender role perceptions” OR “masculinity”) AND (“men” OR “males”)				

## Study Selection

Abstracts and full texts of identified articles were read in order to match them against the eligibility criteria.

## **Quality Appraisal**

Qualitative studies were evaluated using the Critical Appraisal Skills Programme (CASP, 2006) and quantitative papers were reviewed using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies (1998). The areas considered in quality appraisal included study design, sampling method, data collection, analysis method, limitations, findings and overall quality appraisal score.

## **Data Collection Process**

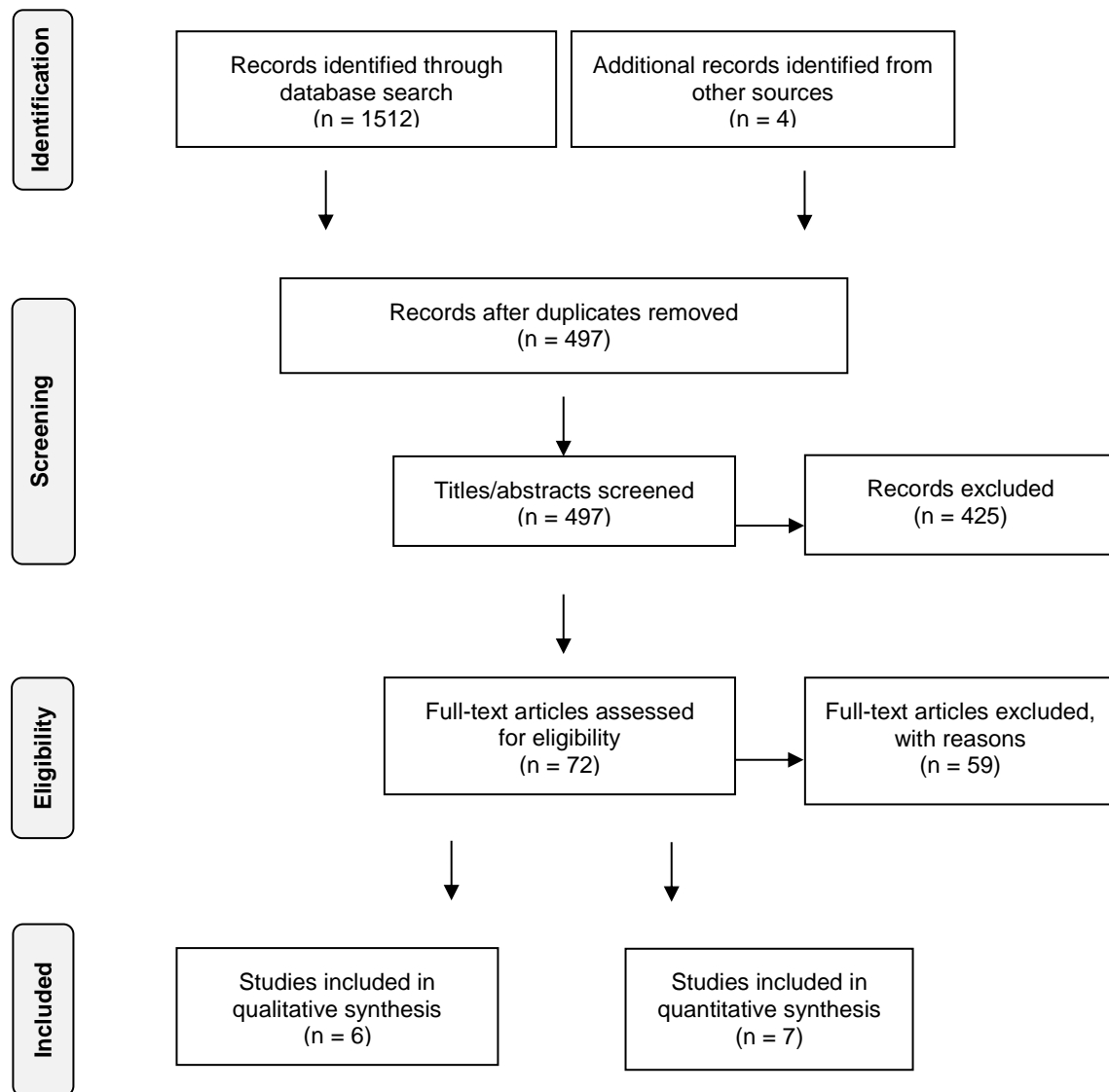
The author of this paper searched for the articles and reviewed them independently.

## **Results**

### **Study Selection**

The flow diagram presented in Figure 1 depicts the process of study selection, based on PRISMA guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009). The diagram details the inclusion criteria and the steps taken following the database search.





*Figure 1.* Search strategy and process of identification, screening, eligibility and inclusion for review.

## Study Characteristics

Details of each of the 13 studies included in the review are presented in two separate tables for quantitative and qualitative studies, in line with relevant PICOS inclusion criteria and appropriate quality assessment tools for these types of study.

**Quantitative Studies**

Table 2 presents the six quantitative studies that met the inclusion criteria of this review.

Table 2

*Quantitative Studies Included in the Review*

ID	Author(s) and Year	Aim(s)	Sample	PTSD Measure	Disclosure Measure	Masculine Norms Measure	Design	Analysis	Relevant Findings	Effect Sizes	EPHPP Rating
1	Banyard et al., 2004	<i>"To investigate CSA effects utilising models that take gender into account [...] it sought to explain variance in psychological symptoms within a sample of male survivors".</i>	Women = 174 Men = 106 This sample was drawn from the records of a hospital in a large city in the United States which reported CSA experiences to the authorities 1973–75. Participants were asked questions on unwanted sexual experiences, based on questions developed by Russell (1984).	The Trauma Symptoms Inventory (TSI; Briere, Elliott & Harris, 1995) is a 100-item measure of post-traumatic symptomatology that consists of 10 subscales including anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation and impaired self-reference. It does not generate DSM-IV diagnoses but evaluates various forms of post-traumatic distress.	Disclosure ability was not measured but help seeking was explored by creating a dichotomous variable in three questions on hospitalisation for MH problems, use of counselling services and use of medication following CSA experiences.	The study did not use a measure of masculine gender norms but sought to explore gender differences in help seeking following CSA experiences and in levels of trauma symptoms.	Correlational study	Multivariate Analyses of Covariance (MANCOVA) were performed examining gender differences in CSA outcomes and help seeking.	Results revealed no differences in help seeking following CSA between men and women. Both groups were equally likely to use medication and/or counselling services and/or to have been hospitalised for MH problems following CSA. Male survivors reported lower scores on post-traumatic stress symptoms, including anxious arousal (Cohen's $d = 0.56$ ), depression (Cohen's $d = 0.18$ ) and defensive avoidance (Cohen's $d = 0.58$ ).	Small to medium	<b>A</b> Strong <b>B</b> Moderate <b>C</b> Strong <b>D</b> Moderate <b>E</b> Strong <b>F</b> Strong <b>G</b> Moderate <b>H</b> Strong <b>Overall</b> Strong

ID	Author(s) and Year	Aim(s)	Sample	PTSD Measure	Disclosure Measure	Masculine Norms Measure	Design	Analysis	Key Findings and Effect Sizes	Effect Sizes	EPHPP Rating
2	Easton, 2013	The study aimed to examine what best predicts mental health problems in men with CSA history: masculine norms or disclosure.	A large, non-clinical sample of men who self-identified as having a history of CSA (n = 487) was recruited online through websites that serve male CSA survivors and which agreed to advertise the study. Participants volunteered by clicking a link to the study.	The study did not measure PTSD directly but explored mental health problems using the General Mental Health Distress Scale (GDMS; Dennis, White, Titus, & Unsicker, 2008). This is a 25-item tool assessing depression, anxiety, somatisation and suicidality.	Qualitative questions were used that explored whether participants had previously disclosed abuse, how old they were at the time and how helpful were the responses they received.	The Conformity to Masculine Norms Inventory-22 (CMNI-22) was used. This explores conformity to 11 features understood to be stereotypically masculine, including use of violence, emotional control and self-reliance.	Cross-sectional design	Multivariate regression analyses using ordinary least square models.	Conformity to traditional masculine norms and delaying disclosure were associated with more mental health symptoms in male CSA survivors ( $f^2 = 0.56$ ).	Medium	<b>A</b> Strong <b>B</b> Moderate <b>C</b> Strong <b>D</b> Moderate <b>E</b> Strong <b>F</b> Strong <b>G</b> Moderate <b>H</b> Strong <b>Overall</b> Strong
3	Hebert, Tourigny, Cyr, McDuff, & Joly, 2009	The study sought to explore patterns of CSA disclosure among adult male and female survivors.	Representative adult sample of men and women from Quebec (n = 804). CSA history was assessed by the two indicators of unwanted sexual touching or intercourse prior to the age of 18.	The study used the Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003) a short 4-item PTSD measure assessing the presence of re-experiencing, numbing, avoidance and hyperarousal.	Disclosure was explored with qualitative questions focusing on whether survivors had disclosed prior to the study and how many years post-abuse.	N/A	Correlational study.	Analysis of Variance (ANOVA) and logistic regression analysis were performed on the data.	A higher proportion of men had not disclosed CSA prior to the study than women (34% and 15.7% respectively). Survivors who delayed disclosure presented higher PTSD symptoms than those who disclosed promptly (Cohen's $d = 0.40$ ).	Small to medium	<b>A</b> Strong <b>B</b> Moderate <b>C</b> Moderate <b>D</b> Moderate <b>E</b> Moderate <b>F</b> Moderate <b>G</b> Moderate <b>H</b> Moderate <b>Overall</b> Moderate

ID	Author(s) and Year	Aim(s)	Sample	PTSD Measure	Disclosure Measure	Masculine Norms Measure	Design	Analysis	Key Findings and Effect Sizes	Effect Sizes	EPHPP Rating
4	O'Leary, Coohey, & Easton, 2010	<i>"This study examined the relationship among severe CSA, disclosure and mental health symptoms in adulthood".</i>	Male and female community sample with a history of CSA (n = 172) of which 19.8% were male. Participants who self-identified as having a CSA history were recruited through posters.	The study did not measure PTSD symptoms directly. A self-report measure of mental health was used, which consisted of questions on the presence or absence of a number of mental health symptoms, including emotional numbness, depression and dissociation among others.	Disclosure was assessed using qualitative questions exploring the presence or absence of disclosure, whether it took place immediately or later in life.	N/A	Within-group cross-sectional study.	Hierarchical regression model predicting mental health symptoms as a function of four steps: age, characteristics of abuse, disclosure and response to CSA disclosure and interactions were tested.	The regression analysis revealed that CSA disclosure at the time of abuse in childhood was related to more severe mental health symptoms in adulthood ( $f^2 = 0.79$ ).	Large	<b>A</b> Moderate <b>B</b> Weak <b>C</b> Strong <b>D</b> Moderate <b>E</b> Weak <b>F</b> Moderate <b>G</b> Moderate <b>H</b> Moderate <b>Overall</b> Weak
5	Okur et al., 2016	The study sought to explore whether there are ethnic differences in help seeking and CSA disclosure among adult survivors and whether these differences can be explained by attitudes towards gender roles and sexuality.	The study used data from 1,496 participants with CSA experiences. 71% of the sample was of ethnic Dutch origin, 5.9% of Dutch Antillean/Surinamese and 11.2% of Moroccan/Turkish heritage. Women represented the majority in of groups.	The study did not measure PTSD.	The study measured disclosure with a set of qualitative questions, which explored telling significant others about abuse in non-professional contexts. The study also measured formal help seeking from professionals using a set of qualitative questions.	The study explored gender role attitudes with a set of four qualitative questions.	Mixed methods design correlational study and qualitative study using focus groups.	Logistic regression was conducted in order to estimate the effects of ethnicity and gender role attitudes on CSA disclosure and formal help seeking from professionals. Focus group data were analysed using content analysis methods.	Men were less likely than women to seek formal help from professionals (5% of men versus 9.9% of women) and to disclose CSA to someone in their social network (35.7% of men in comparison to 55.8% of women). Participants who scored as more stereotypical in terms of their self-reported views on gender roles were less likely to seek informal help within their networks ( $f^2 = 0.45$ ).	Medium	<b>A</b> Strong <b>B</b> Weak <b>C</b> Moderate <b>D</b> Moderate <b>E</b> Weak <b>F</b> Moderate <b>G</b> Moderate <b>H</b> Moderate <b>Overall</b> Weak

ID	Author(s) and Year	Aim(s)	Sample	PTSD Measure	Disclosure Measure	Masculine Norms Measure	Design	Analysis	Key Findings and Effect Sizes	Effect Sizes	EPHPP Rating
6	Ullman et al., 2005.	The study focused on the impact of victim-offender relationship on the disclosure of abuse, social reactions to disclosure and PTSD symptoms of CSA survivors.	Male and female sample. A survey was administered to 733 college students in the privacy of their own home. CSA history was assessed with 15 questions adapted from West, Williams, & Siegal, 2000.	The Foa PTSD symptom severity scale (Foa et al., 1997) was used, which consists of 17 items based on DSM-IV PTSD criteria.	Disclosure characteristics were assessed with qualitative questions exploring presence, timing and type of disclosure.	N/A	Correlational study.	One-way ANOVAs compared CSA outcomes depending on disclosure and PTSD symptoms. Multiple regression models were developed to test associations between gender and disclosure.	Model predicting PTSD symptom severity demonstrated that greater disclosure extent was associated with lower PTSD symptom severity and longer delay of disclosure was associated with more severe PTSD symptoms, regardless of gender ( $f^2 = 0.38$ ). Regression model demonstrated that disclosures of lesser extent met fewer positive reactions ( $f^2 = 0.69$ ).	Small to medium	<b>A</b> Strong <b>B</b> Moderate <b>C</b> Strong <b>D</b> Moderate <b>E</b> Strong <b>F</b> Strong <b>G</b> Moderate <b>H</b> Moderate <b>Overall</b> Strong

*Note:* EPHPP=Effective Public Health Practice Project Quality Assessment Tool. Component ratings: A=Selection Bias, B=Study Design, C=Confounders, D=Blinding, E=Data Collection Methods, F=Withdrawals and Drop-Outs, G=Intervention Integrity, H=Analyses.

## **Evaluation of Quantitative Studies**

The review identified mixed findings in studies that explored associations between PTSD, disclosure and masculine norms in adult male survivors of CSA. Three studies (2, 3 and 6) found that delaying disclosure was associated with more severe posttraumatic symptoms in survivors of CSA. Study 2 focused on a male-only sample. Study 3 did not compare gender groups and drew identical conclusions for both men and women, whereas Study 6 compared male and female survivors and found them to be equally likely to delay disclosure, which was associated with more severe PTSD symptoms. These discrepancies do not allow concluding whether men are more likely to delay disclosure and whether this is associated with more severe PTSD symptoms. Studies 1 and 6 reported both genders as equally likely to disclose, to use counselling services, to use medication or to be hospitalised as a result of the symptoms following CSA experience. Contrasting with the above were the findings from Study 4, which found that more immediate disclosures were related to more severe MH symptoms than disclosures delayed by one year in both male and female survivors. Studies 3 and 5 found that men were less likely to disclose CSA experiences than women. Study 2 also found an association between more stereotypical masculine norms as measured with CMNI-22, delayed disclosure and a greater degree of mental health symptoms. Study 5 likewise reported an association between stereotypical gender norms and delayed disclosure, but the norms were conceptualised differently and were measured and applied to both genders. This does not allow drawing of clear conclusions, although it suggest that men may be less likely to disclose promptly and that delaying disclosure may result in more negative MH outcomes.

### ***Studies exploring posttraumatic symptoms***

Five quantitative studies explored posttraumatic stress symptoms in survivors of CSA. None used the most reliable measures available, which allow formal PTSD diagnoses, such as the SCID-I or CAPS. The findings must therefore be interpreted with caution. Only three studies (1, 3 and 6) utilised validated measures of PTSD. Study 6 used Foa PTSD Inventory, which is based on DSM criteria. Study 3 used a validated but brief Primary Care PTSD Screen whereas Study 1 used the Trauma Symptoms Inventory, which is not based on formal ICD or DSM PTSD criteria. The remaining two studies used measures focusing on a range of MH outcomes including posttraumatic stress symptoms such as the General Mental Health Distress Scale (Study 2) or a number of questions establishing the presence or absence of a range of mental health symptoms such as dissociation, emotional numbness and depression (Study 4).

### ***Studies exploring disclosure***

None of the quantitative studies included in this review used reliable and validated measures of disclosure; their findings must therefore be interpreted with caution. All studies explored disclosure using qualitative questions; these usually covered the presence or absence of disclosure and whether it happened immediately, during childhood, or was delayed into adulthood.

### ***Studies exploring masculine norms***

Only Study 2 explored masculine norms in male survivors of CSA using the CMNI-22 (Mahalik et al., 2003). Study 5 explored attitudes to gender norms among male and female CSA survivors using a set of four qualitative questions. Study 1 did not measure gender or masculine norms directly but did explore gender differences in formal help seeking. Studies 2 and 5 conceptualised



masculine or gender norms differently, which does not allow easy interpretation of their findings.

### **Quality Appraisal**

The scarcity of studies on this topic required inclusion of studies that received a weak rating on the EPHPP tool. This rating mostly applied to studies that did not use standardised outcome measures, but instead utilised their own invalidated brief questionnaires.

### **Qualitative Studies**

This review included seven qualitative studies, five of which consisted of interviews with male and female CSA survivors. Table 3 outlines the details of the qualitative studies which met the inclusion criteria.

Table 3

## Qualitative Studies Included in the Review

ID	Author(s) and Year	Aim(s)	Design/Method	Sample	Analysis	Risk of Bias/Limitations	Findings	CASP Rating
7	Alaggia, 2005	The study sought to explore qualitatively how gender affects disclosure of CSA in light of reports of the adverse effects of delaying disclosure, such as suffering in silence for men, and other possible gender differences. The study sought to explore factors that inhibit and promote CSA disclosure in relation to self, relationships and the wider context.	Participants were interviewed using the long-interview method (McCracken, 1988).	Nineteen female survivors and 11 male survivors aged 18 to 65 were interviewed in a large multicultural Canadian city. Participants were recruited through posters in community settings.	Narrative data analysis was used for theme development regarding the impact of gender on disclosure. Data saturation was reached after 30 interviews.	Reliability of data was ensured through credibility, dependability and confirmability. Participant accounts were based on memories, which may be susceptible to being forgotten, removed, repressed and later recovered. The sample size was small due to the sensitive nature of the subject.	Themes revealed gender commonalities and differences in CSA disclosure experiences. Delaying or withholding disclosure was common and usually precipitated by indirect attempts at disclosure and breakdown for both men and women. Men reported barriers to CSA disclosure relating to their gender and sexual identity, such as fear of homosexuality.	1) ✓ 2) ✓ 3) X 4) X 5) X 6) X 7) ✓ 8) ✓ <b>Overall</b> 4/8
8	Collin-Vezina et al., 2015	The study aimed to explore barriers to CSA disclosure for male and female survivors.	Long interview method was used (McCracken, 1988).	Sixty-seven survivors of CSA in three large Canadian cities were interviewed, 51 of whom were female and 16 were male. Ages ranged between 19 and 69. The sample was obtained from community mental health services among clients accessing counselling.	Grounded theory approach to data analysis was used in order to explore the meanings participants attach to their experiences.	Participants self-identified as survivors of CSA. It was not possible to explore barriers faced by those who never disclosed. Participants' recollections of past abuse may not be accurate. The sample was ethnically and culturally homogenous, therefore social barriers identified may be specific to this group of individuals. No gender comparisons were made.	Over 50% of participants had not disclosed their experiences prior to the study. Disclosure was explored through an ecological, systemic lens. Three types of barrier to disclosure were identified: barriers from within, in relation to others and in relation to the social world.	1) ✓ 2) ✓ 3) ✓ 4) X 5) X 6) ✓ 7) ✓ 8) ✓ <b>Overall</b> 6/8

ID	Author(s) and Year	Aim(s)	Design/Method	Sample	Analysis	Risk of Bias/Limitations	Findings	CASP Rating
9	Draucker et al., 2011	The study aimed to develop a model exploring post-CSA healing process consisting of five frameworks in which disclosure was central to the healing process and was explored in all four stages of the healing model.	Semi-structured, open-ended interviews were carried out.	Ninety-five participants (51% women) ranging in age between 18 and 62 were interviewed. Participant recruitment was guided by adaptive sampling techniques in the community (Campbell et al., 2004). Participants self-identified as having CSA histories and volunteered to participate.	Grounded theory techniques were used. A group of researchers worked on constant comparison analysis to construct each healing framework.	A number of strategies were used to address bias. Formulations of relationships between categories were examined for adequacy by re-examining the indicators and conducting sampling of additional relevant data. The team, which performed the analysis, was debriefed by an advisory board and expert on grounded theory was consulted.	A healing from CSA model was developed suggesting four stages through which healing may occur and in which disclosure was explored within each stage (grappling with the meaning of CSA, figuring out the meaning of CSA, tackling the effects of CSA, laying claim to one's life).	1) ✓ 2) ✓ 3) ✓ 4) X 5) X 6) ✓ 7) ✓ 8) ✓ <b>Overall</b> 6/8
10	Hunter, 2011	<i>"The study aimed to develop a further understanding of disclosure of CSA and gender differences impacting on it".</i> It aimed to explore how and when people with CSA histories decide to tell others about their experiences.	In-depth interviews using narrative approaches.	Thirteen women and nine men aged between 25 and 70 were interviewed. They were recruited via radio and press releases.	Narrative data analysis was used.	The study reported on gender differences, but its findings need to be interpreted with caution due to small sample size. Participants were recruited through advertisements and volunteered to take part, which may have resulted in a biased sample; as a result, the barriers identified may not be representative of survivors who do not seek help.	Participants' experience of CSA disclosure were explored as a life-long process. Themes in three clusters were identified: not telling as a child, telling as a child and telling as an adult. Men identified barriers to disclosing relating to fears of being viewed as homosexuals and shame over their confusion about their sexual and gender identity.	1) ✓ 2) X 3) X 4) X 5) X 6) X 7) ✓ 8) ✓ <b>Overall</b> 3/8
11	Lisak, 1994.	The study aimed to cross-validate previous qualitative findings from research with male survivors of CSA and to explore a number of themes including problems with gender and sexual identity and PTSD symptoms.	In-depth interviews were carried out. Participants also completed the Symptom Check List (SCL-90R).	Twenty-six male survivors of CSA with a mean age of 33.7 years were interviewed. The majority described themselves as European American and were recruited from among college students.	Thematic content analysis of the interviews was carried out and a coding manual was developed for independent coders.	Reliability of the coding system was assured by measuring the agreement between the author and independent coders.	Men reported debilitating issues related to sexuality and masculinity as barriers preventing positive recovery.	1) ✓ 2) ✓ 3) ✓ 4) X 5) X 6) X 7) ✓ 8) ✓ <b>Overall</b> 5/8

ID	Author(s) and Year	Aim(s)	Design/Method	Sample	Analysis	Risk of Bias/Limitations	Findings	CASP Rating
12	Sorsoli, Kia-Keating, & Grossman, 2008	The study aimed to qualitatively investigate CSA disclosure among male survivors.	Men were recruited through posters in a medium-sized American city. Two semi-structured interviews based on a pre-established protocol were carried out with each participant.	Sixteen male survivors of CSA were interviewed.	Content analysis with a set of initial codes was carried out.	The researchers explored their own biases that may have impacted on data collection. The study was influenced by a study with female survivors. The sample was self-selected and thus may not represent barriers to disclosure among non-participants. It was more difficult to recruit men and efforts were made to keep the sample diverse, although most of the men listed their ethnicity as Caucasian.	Participants described lifespan struggles with childhood and adulthood disclosures. Personal barriers and resilience factors were revealed.	1) ✓ 2) ✓ 3) ✓ 4) ✓ 5) ✓ 6) ✓ 7) ✓ 8) ✓ <b>Overall</b> 8/8
13	Teram, Stalker, Hovey, Schachter, & Lasiuk, 2006	This study investigated experiences of male CSA survivors with health professionals.	The study adapted a qualitative methodology of interviews and focus groups carried out in six Canadian provinces.	Forty-six female survivors and 49 male survivors took part in interviews and four focus groups, which also involved professionals.	Interview and focus group discussions were transcribed and analysed using thematic data analysis.	Sample was relatively small and homogenous.	The following barriers to help seeking and disclosure among men were identified: homophobia, lack of concern for boys, being perceived as a potential perpetrator, vulnerability and difficulty in expressing feelings.	1) ✓ 2) ✓ 3) X 4) X 5) X 6) X 7) ✓ 8) ✓ <b>Overall</b> 4/8

*Note:* CASP=Critical Appraisal Skills Programme. Appraisal criteria: 1=Research design, 2=Recruitment strategy, 3=Data collection, 4=Relationship between researcher and participants, 5=Ethical issues, 6=Data analysis, 7=Clear statement of findings, 8=Value of research.

## **Evaluation of Qualitative Studies**

### ***Evidence from Qualitative Studies***

The qualitative analyses revealed disclosure as complex and often lifelong process which, although difficult, contributed positively to long-term recovery of male and female CSA survivors (studies 7, 8, 10, 12). Consciously delaying disclosure, which was often precipitated by a breakdown or mental health crisis, was a common theme across studies (studies 7, 10, 11, 12). Participants spoke of attempting to deny their CSA experiences which placed a burden on them. This resulted in a crisis, a terrifying experience but also one that allowed them to finally speak about what happened. Participants reported having made indirect attempts at disclosure, in which they attempted to make hints to close relatives or give signals that they were distressed; these attempts were abandoned as others failed to notice (studies 7 & 9). All the qualitative studies referred to struggles with disclosure and drew conclusions about what prevented survivors from speaking up. Three studies grouped barriers into three types: personal or from within, in relation to others and in relation to the social world (studies 8, 10, 12). Personal barriers included fear of being viewed as a victim or as homosexual, high levels of shame and an inability to admit to being a man who struggles. In relation to others, men felt unable to disclose due to fragility of their social network. In relation to the social world, men spoke of their awareness of gender differences in reactions to disclosure and feared that professionals would not take their concerns seriously (studies 7, 8, 10, 11, 13). This was related to a societal lack of concern for abused men who are not perceived as potential victims. Study 9 identified disclosure as one of the crucial aspects of healing from CSA in their four-stage model. In the 'grappling with CSA meaning' stage, disclosure was often kept a secret, suppressed due to fear of blame or disbelief. Disclosures in

this stage were reported as not planned and impulsive, which resulted in negative reactions. In the 'figuring out the meaning of CSA' stage, participants reported being more likely to discuss abuse with others whom they deemed safe. These disclosures were planned more carefully and sometimes directed at MH professionals. In the 'tackling the effects of CSA' stage, interviewees described disclosures allowing them to develop a belief that they could heal and that abuse was not their fault. In the last stage, that of 'laying claim to one's life', subjects recalled disclosing to survivors or audiences whose awareness they wanted to raise in order to overcome the stigma attached to CSA.

Study 11 revealed themes relating to masculine norms preventing recovery from CSA. Interviews revealed complex interactions between CSA experiences and victims' perception of their own gender and sexuality. Men spoke of victimisation following CSA which violated male gender roles, which traditionally imply being strong and not struggling in any area, and not being emotionally vulnerable. Recovery was doubly stunted by rigid masculine norms by giving in to the consequences or by trying to fight back. Some men felt inadequate in their masculinity, which resulted in withdrawal, depression and silent suffering; others adopted hypermasculine attributes, including the use of violence, as a way of denying any CSA impact. Both stances prevented men from seeking and accessing help.

### ***Studies Focusing on Disclosure and/or CSA Experiences of Men***

Six studies set out to explore the complex phenomenon of disclosure among male and female survivors of CSA. Only three studies focused solely on male survivors (studies 10, 11 & 12). Narrative analysis, grounded theory or thematic analysis were used although only studies 9 & 12 provided sufficient justification of the choice of a particular qualitative methodology. Two studies used the four-stage

model of qualitative interviewing developed by McCracken (1988), a validated method for carrying out in-depth interviews which is recommended when researchers aim to achieve consistency in interviewing (Prescott, 2011). Some did not describe their data collection and analysis sufficiently (studies 10 & 13). Only Study 12 included sufficient reflections on ethical aspects of research with CSA survivors, the researcher-participant relationship and researchers' epistemological stance, which is an important consideration due to the subjective nature of qualitative methodology and in the interests of minimising bias. Study 11 adapted a broad approach to exploring CSA experiences through autobiographical, in-depth interviews with men. It used thematic analysis, appropriate for the research aim of cross-referencing previous studies carried out with abuse survivors.

### **Quality Appraisal**

Three studies received low ratings on the CASP quality appraisal tool; their inclusion was essential due to the scarcity of studies available on this topic.

## **Discussion**

### **Summary of Evidence**

This review has identified mixed findings regarding the associations between PTSD, masculine norms and disclosure in male CSA survivors. Three quantitative studies demonstrated very limited evidence of an association between delayed disclosure and PTSD symptoms. These findings were not easy to combine due to the different nature of their samples (some male only and some mixed) and the variety of outcome measures used. One study contradicted their findings and reported worse MH outcomes, including posttraumatic stress symptoms among both men and women who disclosed immediately in childhood.

Two studies found no differences in help seeking behaviours between men and women. Two studies reported associations between delayed disclosure and more stereotypical masculine or gender norms, although they conceptualised gender and masculine norms differently. The only study that measured all the outcomes found an association between both delayed disclosure and stereotypical masculine norms and more negative MH symptoms in male survivors. It remains unclear whether male survivors are more likely to delay CSA disclosure than women and whether this may be associated with more stereotypical gender norms and related to higher PTSD symptoms. Future research could address these gaps by evaluating all the outcomes using validated measures and comparing cohorts of men and women.

The findings of the qualitative studies are more consistent as a number of common themes were identified. Both male and female survivors spoke of delaying CSA disclosure. Survivors also reported several indirect attempts at disclosure that were abandoned because others missed the signals they were trying to send. Men and women reported slightly different barriers preventing them from seeking help. Male survivors reported a conflict between societal expectations of men to remain strong and not ask for help and their personal experience of emotional suffering. Women did not report as many themes relating to gender perception or norms. Men also questioned their gender and sexual identity. The findings of the qualitative studies highlighted struggles with disclosure for CSA survivors regardless of gender. Clinical practice with male survivors may be further informed by the findings relating to impact of CSA on their perceptions of masculinity.



## **Limitations and Bias of Reviewed Studies**

There are a number of limitations related to the nature of the studies included in this review. As none took an experimental approach, limited conclusions can be drawn from this process.

Few studies investigated the associations between all the factors of interest in this review: PTSD, disclosure and masculine norms in male survivors of CSA. No study used formal measures to establish CSA history in its sample. Most of the participants volunteered to take part; the findings may not be representative of other barriers faced by non-participants. All of the studies relied on participants self-reporting memories of their early experiences, which could have been modified, repressed or altered. Studies used measures that were unvalidated or not based on formal PTSD criteria; they also measured disclosure with qualitative questions, which did not allow the drawing of firm conclusions.

Men with CSA histories proved difficult to recruit, which meant that some of the study samples were small. Only three had male-only samples. Other studies had samples divided unequally between males and females, which did not always allow gender comparison. The barriers in men that prevent them from disclosing and seeking help may also impact on their ability to participate in studies. These are very difficult to explore due to the high degree of avoidance of dealing with traumatic experiences.

## **Limitations of this Review**

This review has a number of limitations. Only a small number of relevant studies was revealed. Also, the studies identified were heterogeneous in terms of their methodologies; some of them included mixed gender samples, while others focused exclusively on men. This does not allow easy combination of their

findings in a systematic literature review. Heterogeneity was also observed in the measures used to evaluate outcomes, which similarly made comparisons difficult; some studies evaluated PTSD symptoms using validated tools based on DSM criteria while others measured posttraumatic stress symptoms as part of a wider battery of MH symptoms. Due to the scarcity of studies on this topic, it was necessary to adopt broad inclusion criteria in terms of methodologies used and the quality of reviewed papers. The quality of the studies was appraised by CASP and EPHPP, but no resources were available to carry out a second rating.

### **Conclusions**

The above is a systematic review of all published literature available on a number of databases on the topic of PTSD, disclosure ability and masculine norms in male survivors of CSA. It also evaluated qualitative studies, which mainly explored disclosure phenomenon. This review found some preliminary evidence of associations between delaying disclosure and PTSD symptoms in male survivors of CSA and revealed a number of barriers to disclosure. Also, very limited evidence shows associations between more severe PTSD symptoms and more stereotypical gender norms in men; these findings need further investigation. Further exploration of factors contributing to preventing men with CSA histories from disclosing, seeking professional help and accessing evidence-based treatment is warranted. Future studies could also explore directly whether more stereotypical masculine norms lead to delayed or no disclosure, which traps male CSA survivors in silent suffering of PTSD symptoms.

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## Appendices

### Appendix A: The EPHPP (1998) Appraisal Tool



## EFFECTIVE PUBLIC HEALTH PRACTICE PROJECT (EPHPP)

Ref ID: \_\_\_\_\_  
 Author: \_\_\_\_\_  
 Year: \_\_\_\_\_  
 Reviewer: \_\_\_\_\_

### QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

#### COMPONENT RATINGS

##### A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

- 1 Very likely
- 2 Somewhat likely
- 3 Not likely
- 4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

- 1 80 - 100% agreement
- 2 60 - 79% agreement
- 3 less than 60% agreement
- 4 Not applicable
- 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

##### B) STUDY DESIGN

Indicate the study design

- 1 Randomized controlled trial
- 2 Controlled clinical trial
- 3 Cohort analytic (two group pre + post)
- 4 Case-control
- 5 Cohort (one group pre + post (before and after))
- 6 Interrupted time series
- 7 Other specify \_\_\_\_\_
- 8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3



### C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

- 1 Yes
- 2 No
- 3 Can't tell

The following are examples of confounders:

- 1 Race
- 2 Sex
- 3 Marital status/family
- 4 Age
- 5 SES (income or class)
- 6 Education
- 7 Health status
- 8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

- 1 80 – 100%
- 2 60 – 79%
- 3 Less than 60%
- 4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were the study participants aware of the research question?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were data collection tools shown to be reliable?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell

(Q2) Was the consistency of the intervention measured?

- 1 Yes
- 2 No
- 3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

- 4 Yes
- 5 No
- 6 Can't tell

## H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community   organization/institution   practice/office   individual

(Q2) Indicate the unit of analysis (circle one)

community   organization/institution   practice/office   individual

(Q3) Are the statistical methods appropriate for the study design?

- 1 Yes
- 2 No
- 3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

- 1 Yes
- 2 No
- 3 Can't tell

**GLOBAL RATING****COMPONENT RATINGS**

Please transcribe the information from the gray boxes on pages 1-4 onto this page.

<b>A</b>	<b>SELECTION BIAS</b>	<b>RATE THIS SECTION</b> See dictionary	<b>STRONG</b> 1	<b>MODERATE</b> 2	<b>WEAK</b> 3
<b>B</b>	<b>STUDY DESIGN</b>	<b>RATE THIS SECTION</b> See dictionary	<b>STRONG</b> 1	<b>MODERATE</b> 2	<b>WEAK</b> 3
<b>C</b>	<b>CONFOUNDERS</b>	<b>RATE THIS SECTION</b> See dictionary	<b>STRONG</b> 1	<b>MODERATE</b> 2	<b>WEAK</b> 3
<b>D</b>	<b>BLINDING</b>	<b>RATE THIS SECTION</b> See dictionary	<b>STRONG</b> 1	<b>MODERATE</b> 2	<b>WEAK</b> 3
<b>E</b>	<b>DATA COLLECTION METHODS</b>	<b>RATE THIS SECTION</b> See dictionary	<b>STRONG</b> 1	<b>MODERATE</b> 2	<b>WEAK</b> 3
<b>F</b>	<b>WITHDRAWALS AND DROPOUTS</b>	<b>RATE THIS SECTION</b> See dictionary	<b>STRONG</b> 1	<b>MODERATE</b> 2	<b>WEAK</b> 3

**GLOBAL RATING FOR THIS PAPER (circle one):**

- |   |          |   |
|---|----------|---|
| 1 | STRONG   | (four STRONG ratings with no WEAK ratings)          |
| 2 | MODERATE | (less than four STRONG ratings and one WEAK rating) |
| 3 | WEAK     | (two or more WEAK ratings)                          |

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No      Yes

If yes, indicate the reason for the discrepancy

- |   |   |
|---|---|
| 1 | Oversight                                 |
| 2 | Differences in interpretation of criteria |
| 3 | Differences in interpretation of study    |

**Final decision of both reviewers (circle one):**

- |   |          |
|---|----------|
| 1 | STRONG   |
| 2 | MODERATE |
| 3 | WEAK     |

## Appendix B: CASP (2006) Quality Assessment Tool



### 10 questions to help you make sense of qualitative research

#### How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a qualitative research:

- Are the results of the review valid?
- What are the results?
- Will the results help locally?

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

**These checklists were designed to be used as educational tools as part of a workshop setting**

There will not be time in the small groups to answer them all in detail!

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## Screening Questions

### 1. Was there a clear statement of the aims of the research?

☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

### 2. Is a qualitative methodology appropriate?

☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

## Is it worth continuing?



### Detailed questions

#### **3. Was the research design appropriate to address the aims of the research?**

☐ Yes

☐ Can't tell

☐ No

HINT: Consider

- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

---

#### **4. Was the recruitment strategy appropriate to the aims of the research?**

☐ Yes

☐ Can't tell

☐ No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

**5. Was the data collected in a way that addressed the research issue?**

☐ Yes

☐ Can't tell

☐ No

HINT: Consider

- If the setting for data collection was justified
  - If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
  - If the researcher has justified the methods chosen
  - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
  - If methods were modified during the study. If so, has the researcher explained how and why?
  - If the form of data is clear (e.g. tape recordings, video material, notes etc)
  - If the researcher has discussed saturation of data
- 

**6. Has the relationship between researcher and participants been adequately considered?**

☐ Yes

☐ Can't tell

☐ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  - (a) Formulation of the research questions
  - (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

**7. Have ethical issues been taken into consideration?**☐

Yes

☐

Can't tell

☐

No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

**8. Was the data analysis sufficiently rigorous?**☐

Yes

☐

Can't tell

☐

No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation



### 9. Is there a clear statement of findings?

☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

### 10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

## **Appendix C: Clinical Psychology Review – Authors Guidelines**

### **Scope of the Journal**

Clinical Psychology Review publishes substantive reviews of topics germane to clinical psychology. Papers cover diverse issues including: psychopathology, psychotherapy, behaviour therapy, cognition and cognitive therapies, behavioural medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology. Reviews on other topics, such as psychophysiology, learning therapy, experimental psychopathology, and social psychology often appear if they have a clear relationship to research or practice in clinical psychology. Integrative literature reviews and summary reports of innovative ongoing clinical research programs are also sometimes published. Reports on individual research studies and theoretical treatises or clinical guides without an empirical base are not appropriate.

### **Presentation of the Manuscript**

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered. Manuscripts should ordinarily not exceed 50 pages, including references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (<http://www.prisma-statement.org/statement.htm>) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

### **Title Page**

The title should be concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.

### **Abstract**

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to

stand-alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

### **Acknowledgements**

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.)

### **Footnotes**

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

### **Tables**

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules.

### **Reference style**

Citations in the text should follow the referencing style used by the American Psychological Association.

*Examples:* Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton R. A. (2000). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59.

Reference to a book: Strunk, W., Jr., & White, E. B. (1979). *The elements of style*. (3rd ed.). New York: Macmillan, (Chapter 4).

Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B.S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

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**SCHOOL OF PSYCHOLOGY – DOCTORATE IN CLINICAL PSYCHOLOGY**

**EMPIRICAL PAPER**

**The Associations between Posttraumatic Stress Disorder, Disclosure  
Ability and Gender Role Perceptions in Adult Survivors of  
Child Sexual Abuse**

Trainee Name: **Agata Sawicka**

Primary Research Supervisor: **Dr Anke Karl, Senior Lecturer**

Secondary Research Supervisor: **Dr Janet Smithson, Senior Lecturer**

Nominated Journal: **Clinical Psychology Review**

Word Count: **7999** (excl. Headings, Tables, Figures,  
Abstract, Appendices and References)

**Submitted in partial fulfilment of requirements for the Doctorate Degree in  
Clinical Psychology, University of Exeter**

### **Abstract**

Posttraumatic stress disorder (PTSD) affects approximately 69% of adults with child sexual abuse (CSA) experiences. Although the Ehlers and Clark model of PTSD (2000) explains the symptom maintenance cycle in this condition, it is unclear why male CSA survivors are less likely to disclose and seek help. This study proposed incorporating additional perspectives into the cognitive model of PTSD: gender role perceptions as impacting on negative cognitions and disclosure ability as a manifestation of avoidance.

One hundred and fifty CSA survivors took part in an online study, which consisted of validated questionnaires and open-ended questions. Statistical regression and mediation models examined the associations between negative cognitions, disclosure ability, gender perceptions, and PTSD symptoms. Thematic analysis was used to identify themes within disclosure and CSA's impact on gender role perceptions.

Posttraumatic cognitions accounted for most of the variance in PTSD scores. Undifferentiation was associated with PTSD scores via more posttraumatic cognitions; androgyny was associated with fewer negative cognitions about the self and the world. Four key themes in participant disclosure experiences and CSA's impact on gender role perceptions were identified. Clinical implications for therapeutic work with male and female survivors were discussed.

**Keywords:** CSA, PTSD, disclosure ability, gender role perceptions

## Introduction

Posttraumatic stress disorder (PTSD) can occur following the experience or witnessing of a life-threatening event such as military combat or physical and sexual assault. The Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5) characterised PTSD by intrusions or re-experiencing, avoidant symptoms, negative alterations in mood and cognitions, and increased arousal symptoms which need to be present for at least one month (American Psychiatric Association, 2013). PTSD can be treated successfully by trauma-focused exposure-based treatments such as trauma-focused cognitive behavioural therapy (TF-CBT) or eye movement desensitisation and reprocessing (EMDR) (National Institute for Health and Care Excellence, 2005).

Women are twice as likely as men to receive a diagnosis of PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), yet a recent population-based study established that 60% of men experience a traumatic event during their lifetime compared to 50% of women (Galovski, Blain, Chappuis, & Fletcher, 2013). Also, women are significantly more likely to seek help for emotional problems and psychiatric disorders than men (Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Bland, Newman, & Orn, 1993). The discrepancy between men who endure traumatic experiences and those in services suggests that men affected by traumatic events seek help less often.

Less frequent help seeking may especially apply to male sufferers of PTSD who have experienced child sexual abuse (CSA). CSA is the unwanted experience of single or multiple incidents, which may include contact, or non-contact sexual acts prior to the age of 18 (Dube et al., 2005). Rowan, Foy, Rodriguez, and Ryan (1994) highlighted the association of CSA and PTSD: 69% of their adult sample of CSA survivors met the criteria for PTSD; of these, 91%

were female, which was inconsistent with previously published prevalence rates of PTSD after CSA (16% for males and 27% for women). Not seeking help prevents male survivors from accessing evidence-based treatments such as TF-CBT and EMDR. Consideration of the following theoretical perspectives may allow a better understanding of the gender role-specific aspects of PTSD.

### **Cognitive Model of PTSD (Ehlers and Clark, 2000)**

In their model of PTSD, Ehlers and Clark (2000) described a symptom-maintenance cycle in which negative posttraumatic cognitions about the self, others, and the world, and fragmented, vivid, and emotionally charged memories of the event lead to a prevailing sense of serious, current threat. This leads to behavioural (safety behaviours) and cognitive (thought suppression, rumination) avoidance strategies, which in turn prevent successful and adaptive verbal processing of the traumatic event into the person's autobiography (Brewin, 1996, 2000, 2001), thus sustaining PTSD symptoms (Ehlers & Clark, 2000). Inability to disclose CSA experience may be a manifestation of avoidance.

There is evidence for both reduced disclosure (Ullman & Filipas, 2005) and elevated levels of negative self-appraisals, shame, and self-criticism (Banyard, Williams, & Siegel, 2004; Lisak, 1994) in men with CSA history and a few studies point to a possible association between the two factors (Banyard et al., 2004; Easton, 2013). Men interviewed by Lisak (1994) spoke of choosing not to disclose their experiences, as to do so would mean they were not able to cope and would put them in the position of a victim. The experience of disclosure, understood as both sharing with someone close and telling an authoritative body, has been shown to be beneficial for psychological functioning in survivors of CSA (Alaggia, 2005; Everill & Waller, 1994) and has been linked to lower severity of PTSD symptoms (Ullman & Filipas, 2005). Several theoretical frameworks, including

recovery and healing-based theories, have identified disclosure as an important interpersonal process and a critical component of recovery from CSA (Chouliara, Karatzias, & Gullone, 2013; Draucker et al., 2011; Easton, 2013; Harvey, Orbuch, & Webber, 1990). Delaying disclosure until adulthood has been linked to worse mental health outcomes in male survivors of CSA within non-clinical samples (Alaggia, 2005; Easton, 2013). Not disclosing, not seeking help, and thus not accessing evidence-based therapies prevents survivors from breaking this cycle.

Finally, the remaining factor, which may contribute to reducing help seeking amongst male survivors of CSA, is the specific impact of negative cognitive appraisals of the self after CSA and their link with internalised shame and stigma. Male interviewees have reported questioning their masculinity and have often reflected on how their male identity made their experiences shameful, which pushed them to remain silent (Banyard et al., 2004; Kia-Keating, Grossman, Sorsoli, & Epstein, 2005; Lisak, 1994). Negative appraisals about the self and the world (which could lead to the internalisation of shame and stigma) determine the emotional response to traumatic experiences, including cognitive and behavioural responses such as avoidance behaviour or thought suppression, which contribute to the maintenance of PTSD (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Karl, Rabe, Zollner, Maercker, & Stopa, 2009). Findings on the impact of negative self-appraisals in men, which appear to challenge male perceptions of the self, and reduced disclosure may be understood as PTSD maintenance factors within the Ehlers and Clark model. However, incorporating another theoretical perspective could explain some of the gender differences in PTSD among survivors of CSA.



## **Gender Schema Theory (Bem, 1981)**

Sandra Bem hypothesised that men and women possess a high or low intensity of male and female characteristics regardless of their biological sex (1981). Perceptions of societal gender roles are developed through social learning. This leads to evaluating own expectations and behaviours against the internalised schema and influences how the person views himself as a man or a woman (Bem, 1981). The Bem Sex-Role Inventory (BSRI; Bem, 1974) assesses how people identify in terms of psychological gender. People who obtain a low score on one dimension and a high score on the other are classified as sex-typed (feminine or masculine). People with low scores on masculinity and femininity would be classed as undifferentiated, whereas those who score highly on both scales would be classified as androgynous. Bem (1981) argued that the latter have the most adaptive personality and better psychological health, as they are able to draw from different ways of coping, they are not constrained by their biological gender. She also claimed that the undifferentiated group may have worse mental health outcomes due to low self-esteem (1981). Studies comparing mental health outcomes of androgynous, undifferentiated, and sex-typed individuals have resulted in mixed findings (Szpitalak & Prochwicz, 2013). Taylor and Hall (1982) found evidence for the association of masculinity with better psychological health across different measures. People whose scores classify them as sex-typed may hold more stereotypical gender-specific perceptions of themselves. This may be significant for male survivors of CSA due to the perceived obligation to remain strong, consistent with stereotypical masculinity, which may prevent them from disclosing. Studies focusing on male survivors reported difficulties with mental health following CSA experiences and inability to show vulnerability and ask for help (Banyard, 2004; Easton, 2013; Lisak, 1994).

The current study focused on associations between gender role perceptions and PTSD outcomes in survivors of CSA, an area which has not yet been investigated.

**Present Study**

The current study proposed to extend the cognitive model of PTSD (Ehlers & Clark, 2000) by adding disclosure ability as a manifestation of avoidance and gender role perceptions, which have an impact on negative cognitions, as demonstrated in Figure 1.

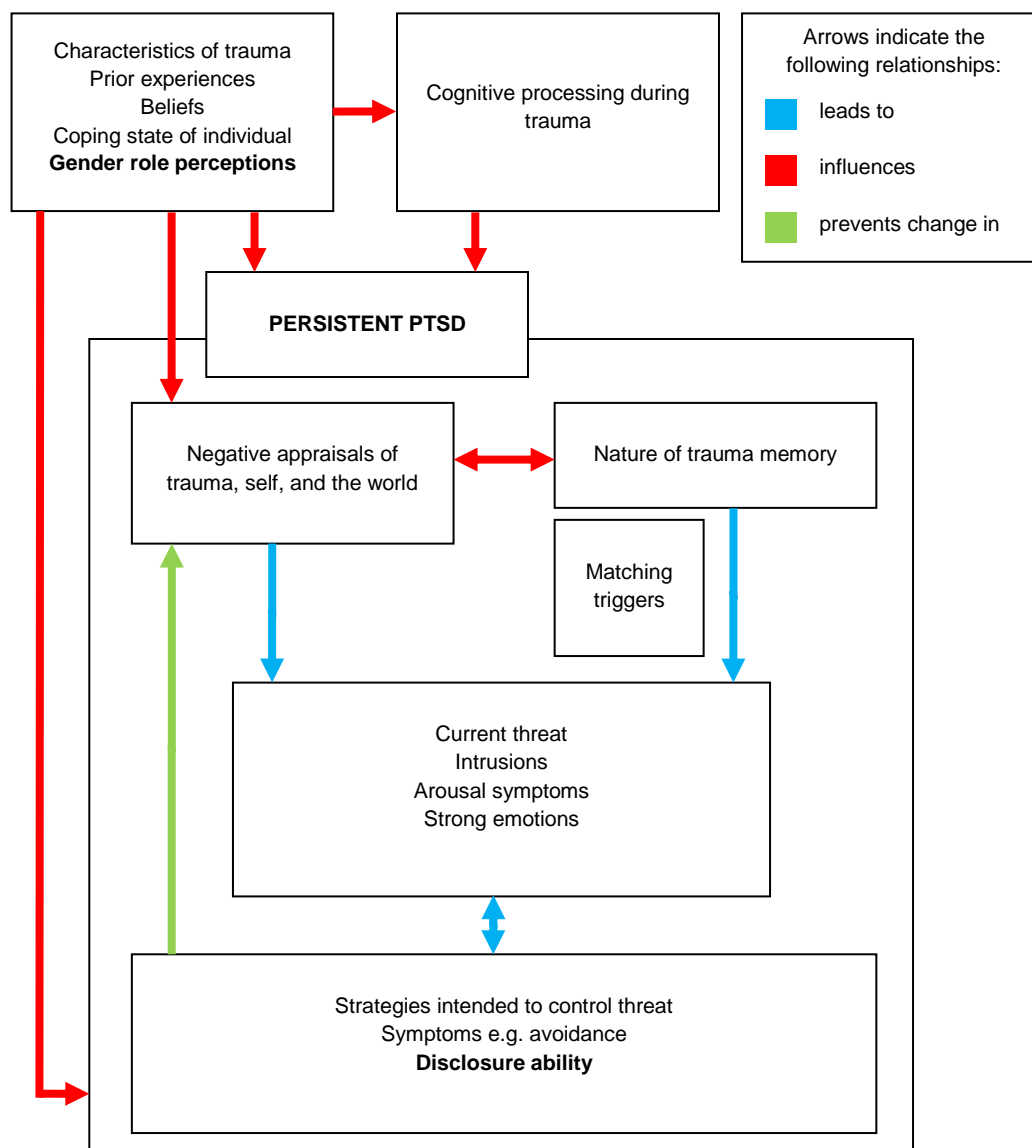


Figure 1. The extended cognitive model of PTSD adapted from Ehlers and Clark (2000).

Negative posttraumatic cognitions about the self, the world, and others activate certain pre-trauma factors, such as core beliefs about the self and perceptions of gender role. This may be important for individuals with less adaptive gender role classifications, such as the undifferentiated and stereotypically masculine and feminine groups (Bem, 1981). Low disclosure ability, as a manifestation of avoidance, may specifically apply to men affected by CSA who have more stereotypical perceptions of masculinity, which prevent them from help seeking. The current study aimed to investigate whether: (a)

maladaptive gender role perceptions (undifferentiated and stereotypically masculine and feminine classifications) are associated with higher PTSD levels via higher levels of negative appraisals and lower disclosure ability; and (b) adaptive gender role perception (androgyny) is associated with lower PTSD levels via lower levels of negative appraisals and higher disclosure ability in male and female CSA survivors. The above associations were tested in the following hypotheses:

1. Hypothesis 1 explored whether the following predictors best explain greater PTSD symptom severity in male and female CSA survivors: posttraumatic negative cognitions as conceptualised in the cognitive model of PTSD (Ehlers & Clark, 2000), and disclosure ability and gender role perceptions as proposed additions to the model. This was tested in a hierarchical regression model and the method of entry was justified by theoretical assumptions (Field, 2003) and existing findings in the literature (Foa et al., 1999; Karl et al., 2009).
2. Hypothesis 2 investigated whether maladaptive gender role perceptions (undifferentiated, masculine, and feminine) predict higher PTSD symptoms via higher levels of negative cognitions and lower disclosure ability, and whether adaptive gender role perceptions (androgynous) predict lower PTSD levels via lower levels of negative cognitions and higher disclosure ability. This was explored in four mediation models in which gender role perceptions were entered as separate predictors, negative cognitions and disclosure ability as mediators, and PTSD levels as the outcome (Baron & Kenny, 1986; Hayes, 2013). In this cross-sectional design, the terms prediction and mediation are referred to in a statistical sense; predictors and mediators were measured at the same time point (Allison, 1999; Hayes, 2013).

In addition, the qualitative component of this study aimed to explore two research questions:

1. What are the experiences of disclosure of CSA in terms of barriers and factors allowing this process?
2. How do individuals describe their CSA experience in terms of gender role perception?

## **Methods**

### **Design**

This study is characterised by a mixed-method design. The quantitative part was cross-sectional and correlational and the qualitative component utilised thematic data analysis.

### **Participants**

One hundred and fifty survivors of CSA, 121 female and 29 male, participated in the study. Table 1 details the participant's demographic information, including scores obtained on the PTSD measure, the Posttraumatic Stress Disorder Checklist (PCL).

Table 1

*Demographic information*

Variable	Women (n = 121)	Men (n = 29)	Total (N= 150)
Age	Mean = 40.35 (12.42)	Mean = 49.34 (9.79)	Mean = 42.09 (12.45)
Ethnicity	n (%)	n (%)	N (%)
Caucasian	109 (90.1)	26 (89.7)	135 (90)
Asian	2 (1.7)	0	2 (1.3)
Mixed	10 (8.2)	3 (10.3)	13 (8.7)
Education	n (%)	n (%)	N (%)
Primary	0	0	0
Secondary	32 (26.4)	9 (31)	41 (27.3)
Bachelor or equivalent	50 (41.3)	8 (27.6)	58 (38.7)
Masters or equivalent	34 (28.1)	10 (34.5)	44 (29.3)
Doctoral or equivalent	3 (2.5)	1 (3.4)	4 (2.7)
No disclosure	2 (1.7)	1 (3.4)	3 (2.0)
Country of Residence	n (%)	n (%)	N (%)
United Kingdom	64 (52.9)	15 (51.7)	79 (52.7)
United States of America	32 (26.4)	9 (31.0)	41 (27.3)
Australia	4 (3.3)	1 (3.4)	5 (3.3)
New Zealand	4 (3.3)	0	4 (2.7)
Canada	8 (6.6)	0	8 (5.3)
Other	9 (7.4)	4 (13.7)	13 (8.7)
PTSD severity (based on PCL score)	n (%)	n (%)	N (%)
No PTSD	50 (41.3)	8 (27.6)	58 (38.7)
Subsyndromal PTSD	9 (7.4)	4 (13.8)	13 (8.7)
Moderate PTSD	8 (6.6)	1 (3.4)	9 (6.0)
Severe PTSD	52 (43)	16 (55.2)	68 (45.3)

*Note:* PTSD = Posttraumatic Stress Disorder, PCL = Posttraumatic Stress Disorder Checklist.

The study was approved by the School of Psychology Ethics Board in September 2015 (details in Appendix A). Participants were recruited online from the United Kingdom and other countries where English is spoken as a first

language. The survey was advertised on survivor websites (Appendices B and C present the email sent and give a list of organisations approached). Individuals were included if they had experienced any form of CSA prior to the age of 18 and excluded if they currently displayed high levels of depression. Participants gave online written informed consent. A priori power calculations carried out to establish the required sample size for the study are detailed in Appendix D. The overall sample was target recruited, although the male sample was under-represented.

### **Measures and Materials**

The content of the online study, created using the LimeSurvey platform (LimeSurvey Project Team, 2012), is detailed in Appendix E.

#### **Patient Health Questionnaire 8 (PHQ-8; Kroenke et al., 2009)**

PHQ-8 is a reliable and valid measure of depression in the general population. It was used to screen out people with high scores on current depression based on the DSM-IV criteria; responses range from 0 (“not at all”) to 3 (“nearly every day”). It does not contain a question on thoughts of being better off dead; it is recommended that this question be omitted from online and over-the-phone administration as adequate intervention is not possible. PHQ-8 allows the grouping of respondents into five categories: no depression (a score of 0–4), mild (5–9), moderate (10–14), moderately severe (15–19), and severe depression (20–24). PHQ-8 has demonstrated good internal reliability with Cronbach’s  $\alpha = .83$  (Pressler et al., 2011).

**Posttraumatic Stress Disorder Checklist, specific version (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993)**

The PCL is a self-report scale assessing 17 symptoms of PTSD as outlined by the DSM-IV relating to a traumatic experience (American Psychiatric Association, 2000). The response options range from 1 (“not at all”) to 5 (“extremely”). The measure allows one to establish whether an individual meets the DSM-IV criteria for PTSD; first the individual’s symptoms are reviewed to determine how they range across the three clusters of symptoms of *intrusions*, *avoidance*, and *hyperarousal*. The following cut-off points are recommended for assessing severity in the general population: a score of 17–33 indicates mild PTSD, 34–44 indicates moderate PTSD, and a score of 45–85 indicates severe PTSD. The PCL is a well-validated measure; it has demonstrated good internal consistency, test-retest reliability, and convergent validity (Blanchard et al., 1996).

**Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999)**

The PTCI is a 33-item scale which measures posttraumatic cognitions in three subscales, on a scale of 1 (“totally disagree”) to 7 (“totally agree”). *Negative cognitions about the self* (PTCI-Self, 21 items) rates the extent of an individual’s negative view of him- or herself as well as thoughts of helplessness and alienation. *Negative cognitions about the world* (PTCI-World, 7 items) focuses on lack of trust in other people and viewing the world as unsafe. *Self-blame* (PTCI-Blame, 5 items) measures the extent to which an individual views an event as his or her own fault. The three scales have shown excellent internal reliability and good test-retest reliability; the PTCI has also demonstrated excellent convergent and discriminant validity (Moser et al., 2010).



### **Disclosure of Trauma Questionnaire (DTQ; Mueller, Moergeli, & Maercker, 2008)**

The DTQ is a self-report questionnaire measuring aspects of an individual's intention to disclose a traumatic event. Respondents indicate the extent to which they (dis)agree with 34 items, responses ranging from 0 ("not at all") to 5 ("completely"). The measure consists of three subscales: 1) *reluctance to talk* (13 items) measures resistance to telling others about the trauma, 2) *urge to talk* (11 items) measures the need to disclose an adverse event, and 3) *emotional reactions* (10 items) measures the individual's affective states during disclosure of trauma. The original 34-item scale demonstrated good psychometric properties with Cronbach's  $\alpha = .82$  to  $.88$  and test-retest reliability of  $.76$  to  $.89$ . In this study, the first two subscales only were included in the analyses; subscale 3 is not directly relevant to the research questions. The psychometric properties of the scales as applied and scored in this study were established; the reluctance to talk and urge to talk subscales demonstrated good reliability (Cronbach's  $\alpha$  of  $.87$  and  $.86$ , respectively).<sup>1</sup>

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<sup>1</sup> Mueller et al.'s scoring guidelines were revised. Items of the subscale *reluctance to talk* were reverse-coded to account for disclosure ability as suggested in the measure's name. The rationale for this was as follows: the creators of DTQ investigated the relationship of their measure and a measure of trauma, the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997), which revealed significant positive correlations between the two scales. The higher their scores obtained on IES-R, the higher participants' scores on the three subscales of DTQ. This was difficult to conceptualise, as both subscales appeared to measure either positive or negative aspects of disclosure. Items in *reluctance to talk* were worded negatively (e.g. "I often think about the event, but *don't* talk about it very much") whereas items in *urge to talk* were worded positively (e.g. "The more often I talk about the event, the clearer it becomes to me").

### **Bem Sex Role Inventory, short form (BSRI; Holt & Ellis, 1998)**

The BSRI is an abbreviated version of a widely used scale designed to measure gender role perceptions, which are internalised through socialisation. The measure is subject to copyright therefore copies for electronic administration were purchased. It consists of 30 items, ten of which are stereotypically feminine (e.g. affectionate, sensitive to needs of others), ten are stereotypically masculine (e.g. forceful, aggressive), and ten are filler items deemed neutral (e.g. conscientious, moody). These are rated on a seven-point Likert-type scale ranging from 1 (“never or almost never true”) to 7 (“always or almost always true”). The BSRI was designed as a measure of psychological androgyny. The scale divided people into four groups: feminine, masculine, androgynous, undifferentiated.<sup>2</sup> The short form correlates highly with the full version, which has demonstrated high internal consistency and test-retest reliability (Holt & Ellis, 1998). Coefficient alphas computed for masculinity and femininity demonstrated high reliability (masculinity  $\alpha = .86$  and femininity  $\alpha = .82$ ).

### **Open-ended questions**

Optional open-ended questions aimed to explore participants’ experiences of disclosure and the impact of CSA experiences on gender role perceptions. The questions were narrow due to constraints of online data collection and the need to focus participants’ reflections on the outlined topics.

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<sup>2</sup> Respondents can be classified as sex-typed when their rating is consistent with their biological gender (men with masculine profiles and women with feminine profiles). They can be classified as cross sex-typed when their profile is not consistent with biological gender; this applies to women with high masculinity and low femininity scores and men with the opposite profile). The scale also distinguishes those who obtain low scores on both scales; these individuals are classed as undifferentiated. Androgynous individuals are characterised by a combination of high masculinity and high femininity scores.

### **Neutralisation/distraction task**

A neutralisation/distraction task designed by the author of the study was included in order to allow an easier transition from the potentially emotive task of the study to participant activities following completion. The task involved watching a 70-second video, which consisted of positive images of animals and landscapes accompanied by a piece of music by Mozart which has positive mood inducing qualities (adapted from Baumgartner, Esslen, & Jancke, 2006).

### **Procedure**

The online study was divided into two parts in order to screen out participants with high levels of current depression measured by PHQ-8. Participants whose PHQ-8 score indicated moderately severe to severe depression were thanked for their participation and informed of available support networks in their country. This was communicated in a gentle manner (Appendix F details the email sent to excluded participants). Participants were allocated a unique number which allowed the linking of their responses to the data obtained in part one.

## **Data Analysis**

### **Quantitative analysis**

Data from the online survey were saved in an SPSS file (IBM Corp, 2013). Three cases missing most data were deleted; other missing values were replaced (Tabachnik & Fidell, 2001). A pattern of data missing due to fatigue causing omissions in latter parts of the study was identified in seven cases only.

In addition, standardised scores (z-scores) were calculated to test for outliers, which were identified as z-scores  $\pm 3.29$  SD (Field, 2013). Data from one participant contained residuals. After this case was excluded, the analysis of

standardised residuals was repeated, revealing no more outliers (Std. Residual Min = -2.52, Std. Residual Max = 2.77).

All variables were checked to determine whether parametric assumptions of normality and homogeneity of variance were met. The results of Kolmogorov-Smirnov and Levene tests and inspection of histograms were consistent with an assumption of normality (Field, 2013). The scatterplot of standardised residuals showed that the data met the assumptions of homogeneity of variance and linearity (Tabachnik & Fidell, 2001). The histogram of standardised residuals indicated that the data contained normally distributed errors (Tabachnik & Fidell, 2001).

A hierarchical, multiple regression to test Hypothesis 1 was conducted, investigating which of the predictors best explain greater severity of PTSD symptoms measured by PCL (posttraumatic negative cognitions, disclosure ability, and gender role perceptions on four levels) in male and female CSA survivors (Aiken & West, 1991; Aguinis, Beaty, Boik & Pierce, 2005). Suppressor effects<sup>3</sup> occurred for DTQ and BSRI androgyny. Strategies of removing variables and testing different variable combinations were tried (MacKinnon, Krull, & Lockwood, 2000). For BSRI undifferentiation and femininity, multicollinearity was a concern<sup>4</sup>. The final model contained no suppressor variables and collinearity diagnostics indicated no concerns.

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<sup>3</sup> This was indicated by sign difference in zero and partial correlations for these two variables. For DTQ, zero-order correlation = -.176 and partial correlation = .127. For BSRI, androgyny zero-order correlation = -.141 and partial correlation = .196. Dramatic and frequent regression coefficient changes depending on the number of variables included in the model is an indication of multicollinearity (Mansfield & Helms, 2012).

<sup>4</sup> For these two variables, Tolerance and Variance Inflation Factor indicated multi-collinearity (BSRI Und, Tolerance= .11, VIF= 8.57, BSRI Fem, Tolerance= .10, VIF= 9.48). Low Tolerance, which ideally would be close to 1 indicates that the variable is almost a perfect linear combination

The PROCESS macro was used to examine mediator effects detailed in Hypothesis 2 to establish whether PTCI and DTQ mediated the relationships between the predictor (gender role perceptions on four levels) and the outcome (PCL; Hayes, 2013). Preacher and Hayes' (2008) bootstrap methods were run in order to test the significance of the mediation effects. Bootstrapping is recommended for testing the significance of indirect effects in mediation; it is more accurate than other methods, such as the Sobel test (Hayes, 2013).

## **Qualitative analysis**

### **Thematic analysis**

To obtain an understanding of experiences of disclosure and the relationships between CSA experiences and gender role perception, thematic analysis (TA) was employed. It seeks to describe patterns across qualitative data; it is positioned between essentialism and constructionism and is not bound to a pre-existing theoretical framework (Braun & Clarke, 2006). TA acknowledges how individuals make meaning of their experiences and also in turn how the broader, social context impinges on these meanings (Namey, Guest, Thairu, & Johnson, 2012). It allows exploration of code frequencies and co-occurrence, and graphic display of the relationships between the codes in the data set. The data was interpreted using framework analysis, which is suitable for homogenous data collected through a set of questions and can organise large volumes of text in order to prioritise the research questions (Gale, Heath, Cameron, Rashid, & Redwood, 2013). In this process, initial ideas noted in the data were used as an analytical framework to continue evaluating participants' responses. This allows

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of other variables and should not be entered. The closer to 10 the VIF value, the more likely that multi-collinearity is of concern (Mansfield & Helms, 2012).

reducing large data sets whilst simultaneously retaining wider meanings (Gale et al., 2013).

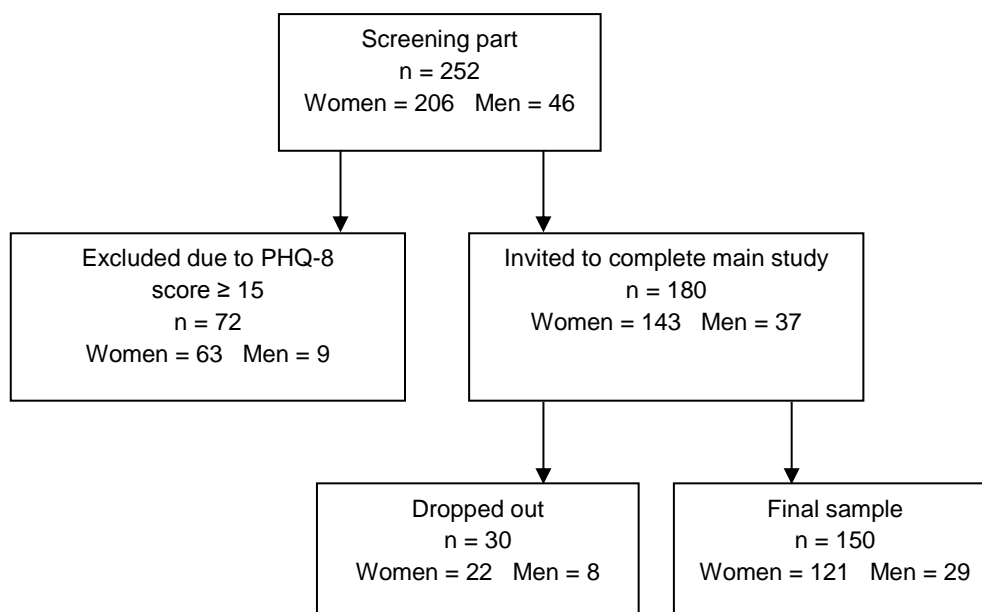
### **Analysis process**

The six steps in thematic data analysis outlined by Braun and Clarke (2006) were followed (details in Appendix G). QSR International's NVIVO 11 (2015) software was used, which allowed familiarising with the data through classifying participants' responses by gender, age group, and country of residence. Initial, structural codes were generated according to two conceptual domains of inquiry (*gender* and *disclosure*). This strategy allowed more efficient identification of patterns in the relatively large data set (Namey et al., 2012). The researcher was immersed in the data and paid attention to how participants described the material relevant to the research questions. Emerging ideas formed the analytical framework (Gale et al., 2013). Themes relating to participants' responses in relation to disclosure experiences and CSA's impact on perception of own gender were grouped and at times reduced to form new, overarching themes. NVivo allowed the allocation of references to each theme, which later facilitated retrieval of quotations (Gale et al., 2013). Observations were noted and evaluated against existing literature. Summarising the findings graphically allowed detailing the relationships between themes.

## **Results**

### **Sample characteristics**

The final sample consisted of 150 participants (121 women and 29 men). Figure 2 shows the recruitment and inclusion flow chart.



*Figure 2.* Recruitment and inclusion flowchart. *Note:* PHQ-8 = Patient Health Questionnaire 8.

### **Achieved effect size and statistical power**

In the hierarchical regression analysis (Hypothesis 1), power was calculated to be sufficient using G\*Power (Arikan et al., 2005; Faul et al., 2007). For the sample of 150,  $R^2 = .13$ , and  $f^2 = .15$ , the calculated power was .997. In Hypothesis 2, power calculation was based on recommendations by Hayes (2013) and Preacher and Kelley (2011), who discussed interpretation of effect sizes in mediation models. A number of effect size calculations are possible via bootstrapping, which is a robust way of testing the significance of effect sizes in mediation (Hayes, 2013). A partially standardised effect size of -.72 for BSRI androgynous impacting on PCL scores via PTCI, bootstrapped confidence interval [-1.00, -.38] was deemed sufficient, as was a partially standardised effect size for BSRI undifferentiated impacting on PCL scores via PTCI of .40, bootstrapped confidence interval of [.14, .67].

## Results of quantitative analysis

Prior to testing Hypothesis 1, the frequencies of the tested variables were compared in four classification groups by BSRI score; Table 2 details the means and SD.

Table 4

### *Frequencies, means, and SD*

BSRI	PCL	PTCI	DTQ
Undifferentiated (n= 42)	50.83 (12.88)	141.40 (41.14)	45.50 (17.33)
Masculine (n= 15)	53.20 (14.32)	123.33 (40.01)	54.47 (20.36)
Feminine (n= 57)	47.95 (15.28)	128.56 (42.78)	47.54 (21.79)
Androgynous (n=23)	44.00 (14.04)	91.78 (37.65)	60.52 (21.15)

*Note:* BSRI = Bem Sex Role Inventory, PCL = Posttraumatic Stress Disorder Checklist, PTCI = Posttraumatic Cognitions Inventory, DTQ = Disclosure of Trauma Questionnaire.

Zero-order correlations were computed to explore the relationships between the outcome, the PCL, and other variables (mediators and predictors); the correlation matrix is outlined in Table 3.

Table 3

### *Correlation matrix for PCL, PTCI, DTQ, and BSRI (Pearson correlation coefficient).*

	1	2	3	4	5	6	7
1. PCL	–						
2. PTCI	.736***	–					
3. DTQ	-.176*	-.362***	–				



4. BSRI UND	.096	.238***	-.150	—			
5. BSRI MAS	.101	-.009	.063	-.206**	—		
6. BSRI FEM	-.016	.056	-.112	-.489***	-.258**	—	
7. BSRI AND	-.129	-.315***	.209**	-.263**	-.139	-.329	—

\* Correlation is significant at the 0.05 level (2-tailed). \*\* Correlation is significant at the 0.01 level (2-tailed).  
\*\*\* Correlation is significant at 0.001 level (2-tailed).

Note: PCL = Posttraumatic Stress Disorders Checklist, PTCI = Posttraumatic Cognitions Inventory, DTQ = Disclosure of Trauma Questionnaire, BSRI UND = Bem Sex Role Inventory Undifferentiated, BSRI MAS = Bem Sex Role Inventory Masculine, BSRI FEM = Bem Sex Role Inventory Feminine, BSRI AND = Bem Sex Role Inventory Androgynous.

Hierarchical multiple regression was run to test Hypothesis 1 to establish which of the predictors (PTCI, DTQ, BSRI) best explained the variance in scores on the PTSD measure (PCL). In the final model, negative cognitions measured by PTCI were entered at step one and BSRI masculinity at step two, with PCL as the outcome (see Table 4 for the model summary).<sup>5</sup>

Table 4

*Hierarchical multiple regression analyses predicting PTSD scores (PCL) from negative, posttraumatic cognitions, and BSRI masculine.*

	$\Delta R^2$	<i>B</i>	S.E.	$\beta$
<i>Step 1</i>				
PTCI	.541	.239	.018	.736
<i>Step 2</i>				
BSRI MAS	.012	5.34	2.69	.111

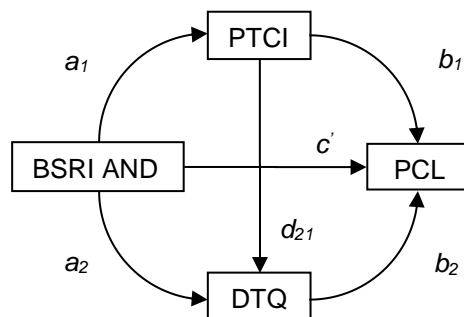
Note: PTCI = Posttraumatic Cognitions Inventory, BSRI MAS = Bem Sex Role Inventory Masculine.

There was a significant main effect of PTCI,  $\Delta R^2 = .541$ ,  $F(1, 145) = 170.98$ ,  $p < .001$ . There was also a significant main effect of BSRI masculinity  $\Delta R^2 = .012$ ,  $F(1, 144) = 3.98$ ,  $p = .04$ . PTCI accounted for 53% of the variance in

<sup>5</sup> When all the predictors were entered in a hierarchical regression model, suppressor effects occurred for DTQ and BSRI androgynous. BSRI undifferentiated and feminine variables demonstrated multicollinearity concerns. This problem was addressed by testing different combinations of variables in a number of regression models. The final model revealed no suppressor effects and no multicollinearity concerns.

the model. BSRI masculinity explained an additional 1% of the variance in the outcome, PCL.

Hypothesis 2, which explored the associations of gender role perceptions on the outcome, PTSD levels, via negative cognitions and disclosure ability, was tested by four mediation models. The Mediation effects of BSRI androgyny through the mediators (PTCI and DTQ) on the outcome (PCL) were tested in the first model detailed in Figure 3.



*Figure 3.* Mediation model for Hypothesis 2. *Note:* BSRI AND = Bem Sex Role Inventory Androgynous, PTCI = Posttraumatic Cognitions Inventory, PCL = Posttraumatic Stress Disorder Checklist, and DTQ = Disclosure of Trauma Questionnaire.

The relationship between androgyny (BSRI AND) and PTSD symptoms measured by PCL was mediated by negative cognitions (PTCI). The standardised regression coefficient between androgyny and PTCI was statistically significant,  $a_1 = -39.60$ ,  $p < .001$ . The standardized regression coefficient between PTCI and PCL was statistically significant,  $b_1 = .26$ ,  $p < .001$ . The standardized regression coefficient between PTCI and DTQ was statistically significant,  $d_{21} = -.16$ ,  $p < .001$ . The significance of the indirect effect of androgyny on PCL via PTCI was computed for each of 10,000 bootstrapped samples. The bootstrapped partially standardised indirect effect was  $-.72$ , 95% CI  $[-1.00, -.38]$ .

Thus, it was statistically significant. The direct effect of BSRI AND on PCL was not significant. Table 5 presents a summary of the model.

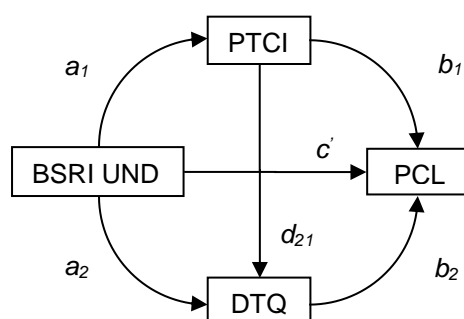
Table 5

*Regression coefficients, standard errors, and model summary information for the mediation model depicted in Figure 3.*

	M1 (PTCI)			M2 (DTQ)			Y (PCL)					
Antecedent	Coeff.	SE	p	Coeff.	SE	p	Coeff.	SE	p			
X(AND)	$a_1$	39.60	9.37	.000	$a_2$	5.56	4.68	.24	$c'$	4.10	2.39	.09
M1(PTCI)	—	—	—	$d_{21}$	-.16	.04	.001	$b_1$	.26	.02	.000	
M2(DTQ)	—	—	—	—	—	—	$b_2$	.06	.04	.16		
Constant	$i_{M1}$	131.40	3.76	.000	$i_{M2}$	69.36	5.50	.000	$i_Y$	12.42	4.08	.003
	$R^2 = .113$			$R^2 = .140$			$R^2 = .540$					
	$F(1, 141)=17.87 \ p=.000$			$F(2, 140)=11.38 \ p=.000$			$F(3, 139)=54.11 \ p=.000$					

*Note:* AND = Bem Sex Role Inventory Androgynous, PTCI = Posttraumatic Cognitions Inventory, DTQ = Disclosure of Trauma Questionnaire, PCL = Posttraumatic Stress Disorder Checklist. X = predictor M1 = first mediator, M2 = second mediator in mediation analysis.

Figure 4 outlines the mediation of psychological undifferentiation (BSRI UND) on PTSD symptoms (PCL) through posttraumatic, negative cognitions (PTCI).



*Figure 4. Second mediation model testing Hypothesis 2. Note:* BSRI UND = Bem Sex Role Inventory Undifferentiated, PTCI = Posttraumatic Cognitions Inventory, PCL = Posttraumatic Stress Disorder Checklist, DTQ = Disclosure of Trauma Questionnaire.

PTCI mediated the relationship between BSRI UND and PCL, but the direct effect was not statistically significant. The standardised regression coefficient was statistically significant ( $a_1 = 23.00$ ,  $p < .001$ ). The bootstrapped

partially standardised indirect effect was .40, 95% CI [.14, .67]. Thus the indirect effect was statistically significant. Table 6 presents a summary of the model.

Table 6

*Regression coefficients, standard errors, and model summary information for the mediation model depicted in Figure 4*

Antecedent	M1 (PTCI)				M2 (DTQ)				Y (PCL)			
		Coeff.	SE	<i>p</i>		Coeff.	SE	<i>p</i>		Coeff.	SE	<i>p</i>
X(UND)	<i>a</i> <sub>1</sub>	23.00	7.73	.003	<i>a</i> <sub>2</sub>	-2.98	3.65	.417	<i>c</i> '	-2.11	1.87	.26
M1(PTCI)	—	—	—		<i>d</i> <sub>21</sub>	-.16	.04	.001	<i>b</i> <sub>1</sub>	.26	.02	.000
M2(DTQ)	—	—	—		—	—	—		<i>b</i> <sub>2</sub>	.06	.04	.16
Constant	<i>i</i> <sub>M1</sub>	118.1	4.23	.000	<i>i</i> <sub>M2</sub>	72.16	4.96	.000	<i>i</i> <sub>Y</sub>	14.20	4.00	.000
	1	<i>R</i> <sup>2</sup> = .060				<i>R</i> <sup>2</sup> = .135				<i>R</i> <sup>2</sup> = .533		
		<i>F</i> (1, 141)=8.86 <i>p</i> = .003				<i>F</i> (2, 140)=10.95 <i>p</i> = .000				<i>F</i> (3, 139)=98.13 <i>p</i> = .000		

*Note:* UND = Bem Sex Role Inventory Undifferentiated, PTCI = Posttraumatic Cognitions Inventory, DTQ= Disclosure of Trauma Questionnaire, PCL = Posttraumatic Stress Disorder Checklist.

Other gender classifications (BSRI masculinity and femininity) did not demonstrate direct or indirect effects on PTSD levels via posttraumatic cognitions or disclosure ability.

## Results of qualitative analysis

Ninety-two women and twenty-one men provided answers to open-ended questions; these were organised using NVivo (2015). The results are researcher's interpretation of the meanings participants attached to experiences of disclosure and the impact of CSA on perception of gender role. The structural codes of *barriers to disclosure*, *facilitators of disclosure*, and *CSA and male and female gender perception* were reviewed for sub themes. Disclosure emerged as often painful but important process; a number of identified *barriers* and *facilitators* reflected the complexity of this phenomenon. Men referred to judging themselves against societal expectations of traditional masculinity resulting in *inadequacy* and inability to show *vulnerability*. Findings concerning CSA and male gender perception need to be interpreted with caution due to small numbers of men in

the final sample. Women reflected on the impact of their experiences on perceptions of themselves as *worthless* and wider consequences for relationships following CSA. Similar themes were grouped in order to generate sub themes such as *lack of CSA awareness amongst therapists* and *contributing towards recovery*, both of which referred to survivors accessing *therapy*. Relationships within themes were reviewed and a *help seeking* structural code to merge two additional themes, *involvement with survivor networks* and *therapy* was used. Figure 5 presents all identified themes.

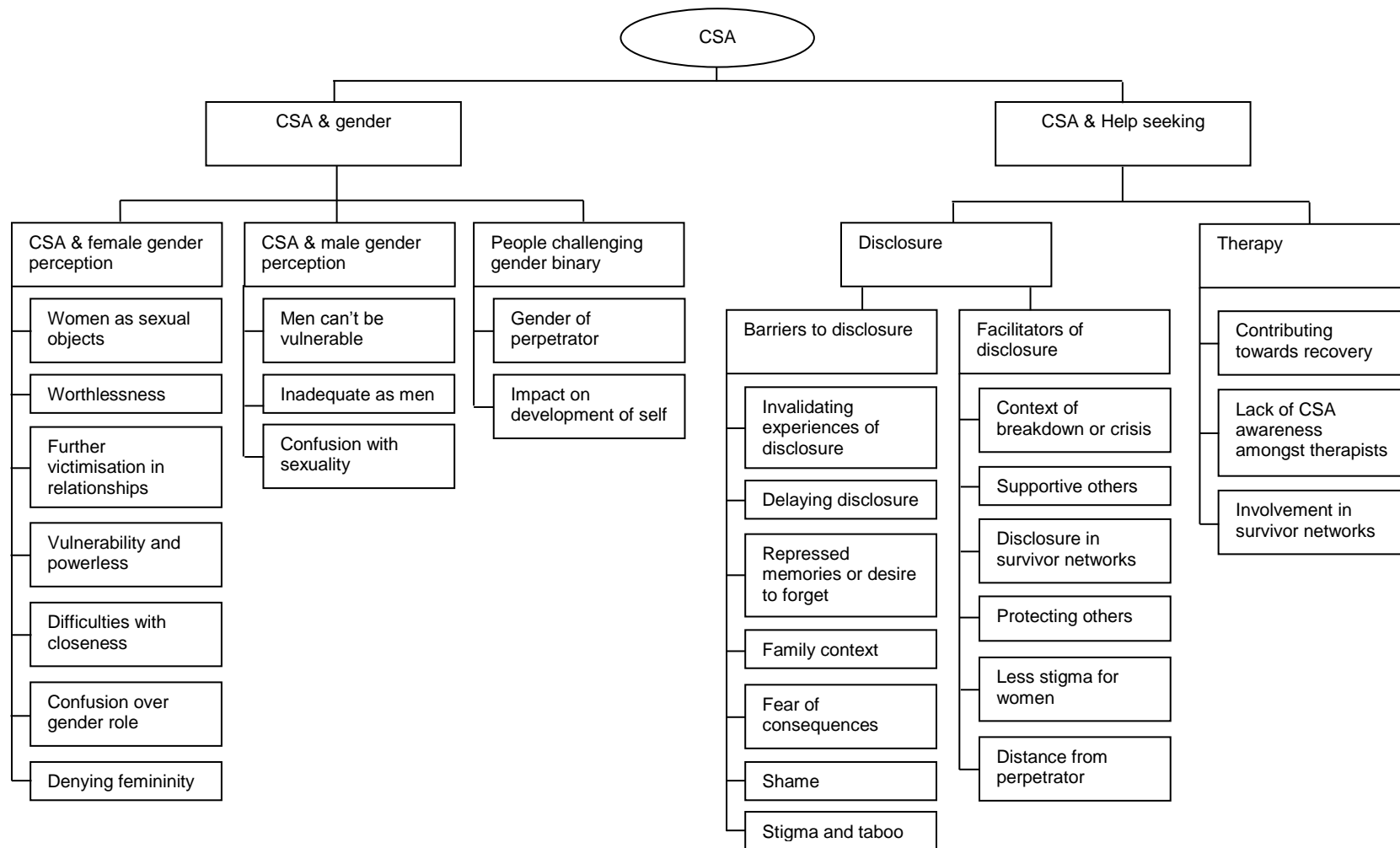


Figure 5. Themes identified in analysis.

This section discusses the most frequently recurring sub themes relating to disclosure and gender roles. Quotations used to illustrate experiences relevant to most common themes are outlined in Appendix H; some examples are included below. Table 7 details the frequencies of identified themes.

Table 7

*Frequencies of themes for both genders*

Theme	Sub-themes
<b>1. Barriers to disclosure</b> (F=104, M=22)	1.1 Invalidating experiences of disclosure (F=51, M=9) 1.2 Delaying disclosure (F=36, M=8) 1.3 Family context (F=28, M=0) 1.4 Repressed memories or desire to forget (F=25, M=2) 1.5 Stigma and taboo (F=23, M=3) 1.6 Shame (F=16, M=2) 1.7 Fear of consequences (F=9, M=1)
<b>2. Allowing disclosure</b> (F=140, M=31)	2.1 Context of breakdown or crisis (F=22, M=11) 2.2 Supportive others (F=41, M=3) 2.3 Less stigma for women (F=14, M=1) 2.4 Protecting others (F=10, M=0) 2.5 Distance from perpetrator (F=9, M=1) 2.6 Disclosure in survivor networks (F=9, M=8)
<b>3. Therapy</b> (F=23, M=6)	3.1 Contributing towards recovery (F=14, M=3) 3.2 Lack of CSA awareness amongst therapists (F=7, M=0) 3.3 Involvement in survivor networks (F=6, M=2)
<b>4. CSA and female gender perception</b> (F=150, M=2)	4.1 Women as sexual objects (F=53, M=1) 4.2 Worthlessness (F=47, M=0) 4.3 Vulnerability and powerlessness (F=35, M=1) 4.4 Confusion over gender role (F=31, M=1) 4.5 Difficulties with closeness (F=29, M=2) 4.6 Further victimization in relationships (F=19, M=0) 4.7 Denying femininity (F=14, M=0)
<b>5. CSA &amp; male gender perception</b> (F=5, M=42)	5.1 Inadequate as men (F=1, M=24) 5.2 Men can't be vulnerable (F=19, M=31) 5.3 Confusion with sexuality (F=0, M=15)
<b>6. People challenging gender binary</b> (F=54, M=7)	6.1 Impact on development of self (F=15, M=0) 6.2 Gender of perpetrator (F=8, M=0)

## 1. Barriers to disclosure

### 1.1 *Invalidating experiences of disclosure*

The devastating consequences of disclosure profoundly affected survivors and often terminated the process. When others failed to take them seriously, they experienced feelings of rejection and low self-worth. Survivors referred to the re-traumatising consequences of not being believed. Recipients of disclosure (often close family members) appeared unable to cope with them; this resulted in a number of unhelpful responses, such as becoming very upset, and rationalising or minimising the crimes of abusers.

P222 “The reactions of other people when told seemed more extreme and threatening than the experience ...”

### 1.2 *Delaying disclosure*

Disclosures took place many years after the abuse stopped; certain personal and relational circumstances had an impact on this. The process needed time. This appeared at times related to the *desire to forget or repressed memories* theme. Complex *family contexts* meant that delays were necessary, leaving abuse secret for years. Participants spoke of the networks in which they grew up “conspiring to silence” and “in denial of the reality of abuse”.

P33 “It took me seven years after it finished to disclose to a counsellor ... I wrote it down on a piece of paper and put it in an envelope and every week when we came to the session I would bring it till I got enough courage to let them open it ...”



## **2. Facilitators of disclosure**

### ***2.1 Context of breakdown or crisis***

Growing exhausted from carrying around “the dirty secret” was common. Many of the disclosures were “forced” when participants arrived at a point of crisis in their mental health. One participant referred to disclosing ‘when the pain exceeded the shame’. Men and women needed to understand the symptoms that became unbearable, or to explain their behaviour to others, including loved ones who did not know about their experiences. These mental health crises were sometimes precipitated by parenthood, which confronted participants with their former child selves.

P23”...I had to. My life was falling apart. I needed to be there to raise my son who was 4 (...) my drug addiction had spiralled out of control and then one day the box that contained all those memories and kept them separate from the rest of me finally opened.

### ***2.2 Supportive others***

Participants spoke of their recovery depending on finding the right support in their networks. At times they tested other people’s trust by revealing a little and gauging reactions. Empathic listening and being believed were identified as the necessary for survivors to start to process CSA experiences. Participants found it incredibly cathartic when others were not horrified by what they were told. The fact that confidants could contain their distress allowed survivors to embark upon the journey of recovery.

P54 “I believed that I could be vulnerable to them and knew that they would hold my story in confidence and support me as I continued to heal ...”

### **3. CSA and female gender perception**

#### **3.1 *Women as sexual objects***

Most women said that the legacy of CSA made them accept being treated as objects of other people's pleasure and having to submit to their sexual wishes and desires. For some, the abuse skewed their view of love and blurred the barrier between love and sex. Some women perceived themselves as "being damaged beyond repair". They spoke of their unequal position in relationships and being unable to voice their own desires; this was related to the theme of *further victimisation in relationships and vulnerability and powerlessness*. Wider processes in society, which still views women as weak and inferior were referred to; this perception was magnified among women who had experienced CSA.

P44 "I have also connected my self-worth to my sexuality ... I have the distorted belief that, in order to matter to a man, he must perceive me as physically attractive ..."

#### **3.2 *Worthlessness***

Women spoke of losing self-worth as individuals due to their experiences. They referred to internalising the blame for what happened. CSA appeared to have a profound effect on the self and personality development.

P16 "I realised they only saw me as an object, or some form of vermin ... they didn't see a human ... I realised that I'd taken this 'inhuman' identity on for my whole life ..."

### **4. CSA and male gender perception**

#### **4.1 *Inadequate as men***

Men questioned their masculine identity following CSA experiences. Some referred to a number of dichotomies in society, such as "weak-strong" and the perception of women as victims and men as abusers. Men mentioned gender

preconceptions to overcome, including the ability to fight back, despite being young children at the time. CSA led to one of two outcomes among men: becoming withdrawn or over-compensating with displays of aggression.

P220 “Men are supposed to be defenders and protectors. I couldn’t even defend myself – how will I ever be able to protect anyone else?”

#### ***4.2 Men cannot be vulnerable***

Male participants appeared to refer to the stereotype of men who do not cry. This appeared to have successfully prevented help seeking and disclosure in some of the accounts. Men referred to being punished for showing emotions and daring to be vulnerable as this did not fit with societal expectations of men. Some accounts of women also referred to more stigma for male survivors.

P7 “society does not accept men that are hurting ... I wish that society could allow men to express themselves in ways that don’t involve violence and hurting others ...”

## **Discussion**

### **The association between negative cognitions, disclosure ability, gender role perceptions, and PTSD levels**

This mixed-methods study aimed (a) to understand the associations between CSA survivors’ gender role perceptions and disclosure ability with PTSD severity and posttraumatic negative cognitions, and (b) to explore CSA survivors’ experiences of facilitators and barriers to disclosure and the role of gender role perceptions. In support of Hypothesis 1, greater PTSD severity was explained by higher levels of negative posttraumatic cognitions and masculine gender role perception. The finding that PTCI is a predictor of PTSD scores is well

documented in literature (Foa, et al., 1999; Karl et al., 2009); this is also in line with the cognitive model of PTSD (Ehlers & Clark, 2000). Contrary to the hypothesis, disclosure ability did not add significant variance to explaining PTSD severity.<sup>6</sup> Extending previous research and supporting gender schema theory, this study also revealed that individuals with a masculine gender role perception have higher levels of PTSD (Bem, 1981; Ullman & Filipas, 2005).

Supporting Hypothesis 2, the study revealed that more negative cognitions mediated the effect of maladaptive gender role perception (undifferentiation) on PTSD severity, whereas the opposite pattern was observed for adaptive gender role perception (androgyny). Thus, the proposed addition of gender role perceptions as a factor impacting negative posttraumatic cognitions to the cognitive model of PTSD (Ehlers & Clark, 2000) was warranted. The findings are consistent with gender schema theory, which suggests psychological androgyny is characterised by more adaptive psychological functioning (Bem, 1981). Bem (1981) characterised the undifferentiated group as low in self-esteem, which may explain higher PTCI levels. A study that examined Bem's gender classifications in a sample of men and women diagnosed with depression found the highest depression levels in the undifferentiated group (Szpitalak & Prochwicz, 2013).

### **Barriers and facilitators of disclosure**

TA generated four main themes relating to disclosure and gender. These are now considered in relation to relevant literature.

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<sup>6</sup> The absence of a significant effect of disclosure ability in explaining PTSD severity was surprising given that previous research has found associations between disclosure and lower levels of PTSD symptoms (Ullman & Filipas, 2005). It is noteworthy that 53% of the variance was already explained by the association between negative cognitions and PTSD, making it more difficult to demonstrate other predictors' effects (Field, 2003).

Consistent with existing literature, disclosure emerged as a complex and life-long process requiring great risk-taking, including facing adverse consequences. Personal and relational barriers to disclosure have been outlined, as has the contribution of wider societal stigma to remaining silent (Collin-Vezina, De La Sablonniere-Griffin, Palmer, & Milne, 2015; Hunter, 2011; Sorsoli, Kia-Keating, & Grossman, 2008). The current study has demonstrated that the defences employed by recipients of disclosure to cope with their own anxiety and guilt, such as rationalisation, are often experienced by survivors as invalidating. At times, disclosure emerged as a profoundly punishing process due to the consequences. These appeared to leave survivors questioning their self-worth and could contribute to higher levels of posttraumatic negative cognitions. *Delaying disclosure*, common in the literature (Alaggia, 2005; Hunter, 2011; Lisak, 1994; Sorsoli et al., 2008) was associated with a number of personal and relational factors, such as *desire to forget or repressed memories* and *family context*. Carrying the secret was a burden on survivors, and resulted in crisis. Contrary to other findings (Alaggia, 2005; Hunter, 2011; Lisak, 1994; Sorsoli et al., 2008), this study revealed that disclosure at breakdown point is not necessarily driven by a desire to be heard, but may be a necessity when the burden and pain associated with it become unbearable. Consistent with other studies, disclosure was found to contribute positively to the long-term recovery of CSA survivors, especially when they found adequate support (Alaggia, 2005; Draucker et al., 2011; Hunter, 2011; Sorsoli et al., 2008).

### **Experiences of CSA and gender role**

In terms of impact on female gender perception, women spoke of CSA's effect on their self-development as worthy human beings. They also referred to feeling powerless in relationships and vulnerable to further victimisation, which is

consistent with other studies (Allagia, 2008; Banyard, Arnold, & Smith, 2000). This could have been associated with low self-esteem and high levels of negative cognitions. This study also found that women survivors often challenged gender stereotypes in the theme *people challenging gender binary* and noted that their recovery depended on it; this appears to be consistent with the quantitative finding that androgyny is protective in terms of fewer negative cognitions and indirect association with PTSD levels. In this study, a number of women indicated that male recovery is more difficult due to societal stigma. Male participants spoke of feeling inadequate as men and unable to show vulnerability. This is consistent with other findings (Easton, 2013; Lisak, 1994) and could have impacted on smaller numbers of men in the final sample. This stigma may have prevented men from seeking help online and spotting the study advertisement. A study in which resilient male survivors were interviewed, having to reflect on conventional masculinity was reported. This was manifested in expected toughness and not showing emotions. Recovery was attributed to acknowledging and reframing these traditional masculine roles following CSA experience (Kia-Keating et al., 2005). Learning from the current process suggests that in order to meet male survivors' needs, concerted efforts to challenge societal stigma around vulnerability are required.

### **Evaluation of the mixed-methods approach**

Discussion of the findings from both quantitative and qualitative perspectives requires caution due to different methodologies used. The addition of disclosure ability to the cognitive model of PTSD was not warranted (Ehlers & Clark, 2000), although zero-order correlations between DTQ, PTCI, and BSRI androgynous were significant. In the qualitative findings, disclosure emerged as being often delayed, which may be a manifestation of avoidance. Delay also

prolonged suffering, which could trap survivors in debilitating PTSD symptoms. TA of the impact of gender role perceptions on recovery from CSA suggested similarities with the identified associations of less adaptive gender roles on PTSD levels through negative cognitions. Survivors' positive recovery stories often emphasised challenging dichotomies, such as gender binary; this appears to be consistent with the association between BSRI androgynous and fewer negative cognitions explored in the mediation model. Male survivors, who felt inadequate against societal stereotypical perceptions of masculinity, appeared to reflect less positive views of the self, others, and the world. Women who referred to feelings of worthlessness and being treated as sexual objects, spoke of reframing society's traditional, stereotypical views of women as necessary for recovery. As the male sample was very small, these findings need to be interpreted with caution.

### **Limitations and strengths**

This study had a number of limitations. It excluded individuals who displayed high levels of depression when PTSD and depression are common following trauma. A number of studies have demonstrated the presence of more than one Axis I disorder following a traumatic experience, and PTSD and depression were the most common combination (O'Donnell, Creamer, & Pattison, 2004). Due to this association, excluding participants with high levels of depression went against the therapeutic stance and the clinical experience of the researcher but was necessary for ethical considerations. This could have resulted in a less representative sample of participants with CSA experiences, as high levels of PTSD and low levels of depression are less common in populations of trauma survivors (O'Donnell et al., 2004). In addition, exclusion denied those most in need a chance to share their experiences and to be listened to. Some

excluded participants contacted the researcher to express their concerns about not being heard.

BSRI, the measure of gender role perceptions, has been criticised for its scoring procedures and some researchers raised concerns over a lack of revisions to the manual. Hoffman and Borders (2001) compared two scoring methods that produced different classifications for a significant part of their sample.<sup>7</sup> This study utilised the scoring method of median-split recommended by Bem. Holt & Ellis (1998) examined its validity and concluded that although gender role perceptions have altered over the last few decades, this was not sufficient to invalidate the BSRI as a measure exploring psychological androgyny at the time of testing. It continues to be widely used in research internationally.

The current study utilised standardised methods to assess disclosure, because previous studies used qualitative questions only. The researcher decided to diverge from the recommended scoring of DTQ, which allowed better conceptualisation of disclosure as a positive phenomenon and avoidance of it as associated with higher PTSD symptoms, which is consistent with the literature (Ullman & Filipas, 2005).<sup>8</sup>

This study also had certain strengths. First, it reached CSA survivors worldwide. This demonstrated that survivors are willing to tell their story and

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<sup>7</sup> Two scoring methods have been described in the literature: median split and hybrid. Median-split establishes how participant scores on femininity and masculinity scales are positioned against the median of both scales as bases for classification. The hybrid method consists of median-split and the difference between the masculinity and femininity scores (Hoffman & Borders, 2001).

<sup>8</sup> The *reluctance to talk* subscale from the DTQ was reverse scored. The two subscales of *urge to talk* and *reluctance to talk* appeared to measure different aspects of the disclosure process. This decision diverged from the scoring advice of the authors of the DTQ, but was deemed necessary as some of the items were worded positively and some negatively.



counters the preconception that CSA is too shameful to be investigated. More survivors expressed interest than the study was able to accommodate due to exclusion criteria; many survivors contacted the researcher to express their gratitude for the interest in the topic and in raising awareness of the consequences of CSA. Second, its mixed-method design allowed exploration of the topics of interest from multiple perspectives, including investigating associations and exploring meanings. To the author's knowledge, this is the first study to evaluate the associations between gender role perceptions (including androgyny, undifferentiation, and stereotypical classifications) and PTSD levels in a group of CSA survivors.

### **Conclusion, Clinical and Future Research Implications**

This study aimed, first, to explore whether levels of PTSD symptoms were associated with posttraumatic cognitions, disclosure ability, and gender role perceptions following CSA experience. Second, it investigated whether the association between gender role perceptions and PTSD levels was mediated by negative cognitions and disclosure ability. Finally, the study explored survivors' experiences of disclosure and the meanings attached to its impact on gender perception.

The study provided preliminary evidence concerning maladaptive and adaptive gender role perceptions and their associations with posttraumatic cognitions. It highlighted barriers and factors contributing to disclosure as well as the more damaging impact of stereotypical gender perceptions on survivor recovery. It challenged the perception of CSA as a taboo subject that few survivors are prepared to talk about. As most participants were female, this revealed the significance of likely rigid barriers and stigma for men, which appeared to prevent them from seeking help in online forums. As some of its

findings are significant, this paper is in a position to provide advice for services supporting male and female CSA survivors. It is necessary to promote proactive coping strategies regardless of psychological gender; this may be an important step towards recovery in CSA survivors. Future research should concentrate on clinical populations and aim for large, gender-balanced samples that would allow further exploration of the barriers to help seeking among men.

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## Appendices

### Appendix A: Ethical Approval Letter



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29<sup>th</sup> of September 2015

Dear Ms Sawicka,

Following recent review by the Ethics Committee for Psychology at the University of Exeter, I can confirm that your application entitled "Gender role perceptions and disclosure ability in survivors of child sexual abuse." (2015/949) has been approved for the duration of your project.

You may now proceed with data collection at your soonest convenience.

Sincerely,

A handwritten signature in black ink, appearing to be "TK", with a long horizontal stroke extending to the right.

Dr Tim Kurz  
*Ethics Committee Chair for Psychology*

## Appendix B: E-mail to Organisations Supporting Survivors

Dear Team at [Forum/Website Name]

My name is Agata Sawicka and I am a Trainee Clinical Psychologist studying for a Doctorate in Clinical Psychology at the University of Exeter in England, United Kingdom. I am conducting an online study with ***adult survivors of child sexual abuse*** that aims to investigate individual differences in emotional responses to experiences of child sexual abuse. I would like to reach out to survivors interested in taking part in my study and therefore kindly request your help in ***advertising the study on your website***. The participation is voluntary, anonymous and confidential. The online study does not record IP addresses, participants' location or times of study completion. All participants are invited to read the information sheet prior to deciding about taking part. Also, they are informed of their right to withdraw their data at any point without providing a reason.

The study has been granted ethical approval by the School of Psychology at the University of Exeter's ethical committee. The committee ensures the highest ethical standard of all research undertaken within Psychology at the University of Exeter. If the participants decide to take part, they will be invited to follow a link to a website where they can fill out a few questionnaires and answer some open-ended questions. They will find some information about the study when they log in. Only the participant and the researcher will have access to the data, which will be stored securely. There are no direct benefits for participants for taking part. The questionnaires will allow the researcher to answer some questions about the experiences of adults on coping with their experiences of child sexual abuse. This could help us to develop better psychological treatments for survivors affected by experiences of child sexual abuse.

The questionnaires in this study are widely used and well tolerated within the population of survivors. The questionnaires might upset the participants temporarily as they might bring back the memories of their experiences and might elicit some feelings in them. The online study will contain phone numbers of helplines and support groups in different countries if the participants wished to seek additional help. The participants would be encouraged to see their GP if they are concerned. The data obtained from the study will be combined with that of other participants to be written up as part of the Doctorate of Clinical Psychology course fulfillment. The study will be written up to appear in one of the scientific journals. This will be achieved in order to inform other clinicians and scientists who are working to support people affected by traumatic experiences and their families. Any write-up will not mention the participants personally, nor detail their name or any other personal detail. No other identifiable information will be published with the results. The participants can request that a copy of the findings is sent to them when it becomes available.

If participants have any concerns about any of the aspects of this study they can contact the researcher or the study supervisor, Dr Anke Karl.

**Researcher**

Agata Sawicka, Trainee Clinical Psychologist, Email: [as678@exeter.ac.uk](mailto:as678@exeter.ac.uk)  
**Study Supervisor** Dr Anke Karl, Email: [A.Karl@exeter.ac.uk](mailto:A.Karl@exeter.ac.uk)  
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School of Psychology, College of Life and Environmental Sciences  
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If you are happy to advertise this study on your website, the following brief information which includes the link to the study can be posted.

**Invitation to participate in exciting new online study designed at the University of Exeter, UK**

Researchers from the University of Exeter are conducting an international survey on emotion processing in adult survivors of childhood sexual abuse and would like to invite adults who are interested in taking part. Please click in the link below to find out more about this anonymous and confidential study:

<http://survey.ex.ac.uk/index.php/survey/index/sid/822763/newtest/Y/lang/en>

Thank you very much for considering my request. Please don't hesitate to contact me for further questions.

Yours sincerely,  
Agata Sawicka

## **Appendix C: List of Contacted Organisations**

1. After Silence
2. Pandora's Project
3. I Survive
4. Help for Adult Victims of Child Abuse
5. The National Association for People Abused in Childhood
6. Survivors' Trust
7. Rape Crisis Network Ireland
8. Canadian Centre for male Survivors of Child Sexual Abuse
9. Living Well Australia
10. Stop It Now
11. Survivors and Mates Support Network
12. Breavehearts
13. Male Survivors of Sexual Abuse New Zealand
14. Devon Rape Crisis
15. Adults Surviving Child Abuse
16. Mood Disorders Centre
17. Survivors UK
18. Abused Men in Scotland
19. Rape and Sexual Abuse Support Centre
20. Devon Rape and Sexual Abuse Helpline
21. Mpower-Supporting Male Survivors of Sexual Abuse
22. Rape, Abuse & Incest National Network
23. 1800 Respect
24. Adults Surviving Child Abuse Australia
25. National Association of Adult Survivors of Child Abuse New Zealand
26. 1 in 6 Support for Male Survivors of Child Sexual Abuse
27. End Abuse Wisconsin
28. Speaking Out About Rape
29. Culture of Abuse
30. Domestic Violence and Sexual Assault Issues in Alaska
31. Arkansas Coalition Against Sexual Assault
32. California Coalition Against Sexual Assault
33. Colorado Coalition Against Sexual Assault
34. Washington DC Rape Crisis
35. Florida Council Against Sexual Violence
36. Georgia Network to End Sexual Assault
37. Idaho Engaging Voices
38. Illinois Coalition Against Sexual Assault
39. Iowa Coalition Against Sexual Assault
40. Louisiana Coalition Against Sexual Assault
41. Massachusetts Coalition Against Sexual Assault
42. Minnesota Coalition Against Sexual Assault
43. Mississippi Coalition Against Sexual Assault
44. Montana Coalition Against Domestic and Sexual Assault
45. New Jersey Coalition Against Sexual Assault
46. New York State Coalition Against Sexual Assault
47. New Mexico Coalition Against Sexual Assault
48. New York City Alliance
49. North Carolina Coalition Against Sexual Assault
50. Child Abuse.Org.UK

51. Stop the Shame
52. Ending Silence
53. Supporting Survivors UK
54. Shatter Boys UK
55. Abused in Chicago
56. Independent Inquiry Into Child Sexual Abuse
57. Self Care After Rape
58. PTSD Resource Center
59. My PTSD Forum
60. PsychForums
61. Mankind UK
62. Towards Peace
63. Men's Mental Health
64. Survivor Chat
65. Survivors Chat
66. Bristol Zero Tolerance
67. Voices of Hope
68. Sexual Assault Prevention and Response Services
69. Trauma Centre
70. Voice for Victims
71. Survivors Secrets
72. Together We Heal
73. Cardiff Womens Aid
74. Rape Crisis Cape Town
75. Survive
76. Stop Child Abuse
77. Stop Ritual Abuse
78. Safe Services Exeter
79. Promoting Awareness, Victim Empowerment
80. Silence is the Enemy
81. Stop Sexual Abuse
82. Safe World for Women
83. Cheshire Without Abuse
84. Stop the Silence
85. Standing Together
86. Edinburgh Rape Crisis
87. Male Survivors
88. Male Survivors Trust
89. One in Four
90. Survivors Collective
91. Healing Complex PTSD
92. Speaking Out
93. Rethink Mental Illness
94. Child Sexual Abuse Awareness
95. Survivors Manchester
96. Mankind Counselling
97. Rape Crisis Scotland
98. Cambridge Rape Crisis

## Appendix D: Power Calculations

The required sample sizes to answer hypothesis 1 have been calculated using G\*Power (Faul et al., 2009) for linear regression approaches, requesting significant  $R^2$  changes for each predictor. In particular, for Hypothesis 1, assuming an  $R^2$  change of .1 for each step and including 6 predictors (PTCI, DTQ, and BSRI on four levels) would require 90 participants (45 men and 45 women) for an expected power of .80.

For the sample size recommendations applicable to mediation hypothesis 2, the recent considerations by Fritz and MacKinnon (2007) and Rucker et al. (2011) have been followed which suggest that for medium to large effects of the a and b paths and when applying robust boot strapping procedures my target sample size of 71 is appropriate (recommended sample size in Fritz and MacKinnon is between 34 to 71). Again, I will be unable to detect small effects and will therefore cautiously interpret any absence of indirect effects should I be unable to recruit substantially beyond this target minimum sample size. Appropriate data analyses based on the actually recruited sample and the balance of the recruited gender subsamples will be carefully considered with my quantitative supervisor. All attempts to recruit a larger sample than the above described minimum target sample size of 90 (45 for each gender) will be made.

## **Appendix E: Content of the Online Study**

### *Information sheet for participants*

#### **Welcome to part one of the "Study for abuse survivors".**

I would like to invite adult survivors to take part in a study that seeks to better understand the emotional responses following difficult experiences of child sexual abuse. Please respond to all the questions if you have sustained any form of child sexual abuse or unwanted sexual experience prior to the age of 18. Your participation is voluntary and completely anonymous.

This study is carried out in two parts. You will now be asked to complete some questions, for information and screening purposes, which will take no more than 5 minutes. After completion of these questionnaires, you will be emailed to discuss next steps. If you are eligible, you will be invited to fill out some questionnaires.

#### **What does the participation involve?**

If you decide to take part in this study, you will be invited to answer the screening questions. This study consists of different types of questions. Some of them will ask you about your responses and thoughts following your experience of child sexual abuse or unwanted sexual contact prior to the age of 18. Some of the questions will focus on your current mood and your personality.

#### **Do I need to take part?**

The participation in the study is voluntary. The study aims to seek out survivors of child sexual abuse worldwide and the participation is voluntary.

#### **Can I save and return later?**

It is better to complete the survey at once, with no breaks. Part one only takes about 5 minutes to complete. If you need to save and return, click on 'Resume later' at the bottom of the screen at any point in the study. You will be directed to another screen where you will be asked to give yourself a name or pseudonym (it does not have to be your real name) and a password. You can enter your email address optionally too, then your name and password would be sent to you. When you want to continue you can click on 'Load unfinished survey' at the bottom of the screen and what you already completed won't be lost.

#### **What if I don't want to carry on with the study?**

All participants have the right to withdraw their data from the study at any point without having to give a reason.

#### **What are the possible benefits of taking part?**

There are no direct benefits for you. The questionnaires you fill out will allow the researcher to answer some questions about the experiences of adult survivors on coping with their experiences of child sexual abuse. This could help us with refining and extending psychological therapies following child sexual abuse experiences.

#### **What are the disadvantages of taking part in this study?**

The questionnaires might upset you temporarily as they might bring back the memories of your experiences or elicit some feelings in you. The online study will

direct you to support groups in your area and provide useful contact numbers in case you decide to seek additional help. If you are concerned at any point it might be helpful to see your GP.

### **What will happen with the results of the research study?**

The data will be stored securely on a server and only the author of this study will have access to the data. The data obtained from your study will be combined with that of other participants to be written up as part of the Doctorate of Clinical Psychology course fulfilment. The data will also be stored securely following the data collection. The study will be written up to appear in one of the scientific journals. This will be achieved in order to inform other clinicians and scientists who are working to support people affected by traumatic experiences and their families. Any write-up will not mention the participants personally, nor detail their name or any other personal detail. No other identifiable information about you will be published with the results. You can request that a copy of the findings is sent to you when it becomes available.

### **Who has reviewed the study?**

The appropriate ethical committees within the University of Exeter, United Kingdom approved the research study to ensure the highest ethical standard.

### **What to do if there is a problem?**

If you are experiencing any technical problems or have any questions or queries about the study, please email the researcher (the email address is provided below).

### **Thank you for your time.**

Agata Sawicka  
Trainee Clinical Psychologist  
University of Exeter  
Exeter  
Devon  
United Kingdom  
as678@exeter.ac.uk

## **Study Part 1**

### **1. Consent**

I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason. I understand that there will not be an option to omit answers to questions for the online questionnaire. I understand that all data will be coded with a participant number and remain completely anonymous to all except the researcher for this study (the researcher needs your email address so that you can be contacted with a link to the main study). All data collected will be treated as completely confidential. I wish to take part in this study: [Yes or No]

This study is confidential. You will be asked to fill out the questionnaires anonymously. No one will be able to identify you, as you will not be asked to state your name or any other identifying details. Your data will be stored securely on a



server and only the principal investigator (Agata Sawicka) will have access to it. Please indicate below if you wish to proceed further: [Yes or No]

Please enter your full email address. This is required, so that the researcher can send you the second part of the study. This information will be kept securely and only the principal investigator will have access to it. [Blank space]

## **2. Screening questions**

Have you ever experienced any unwanted sexual encounter/ child sexual abuse (Including sexual assault, attempted rape, were made to perform any type of sexual act through coercion, force or threat of harm) that you did not consent to and/or that was imposed on you prior to the age of 18? Please note that your experience at the time might not have felt unwanted if you were coerced by another person. [Yes or No].

Some people with similar experiences find it helpful to state what experiences they sustained in their childhood when taking part in research studies. Please use the following space to briefly describe your experiences if you wish to do that. Please ignore if you would prefer not to write about them [Blank space].

## **3. Demographic questions**

1. What is your age? [Blank space]

2. What is your gender? Female or Male

3. What is your ethnicity?

Caucasian Hispanic Asian Mixed Other Prefer not to state

4. What is your level of education?

Primary Secondary Batchelor Masters Doctoral Prefer not to state

5. What country do you live in?

UK USA Australia New Zealand Canada Other Prefer not to state

**Patient Health Questionnaire-8 (PHQ-8)**

		Not at all	Several days	More than half the days	Nearly every day
PHQ.1	Little interest or pleasure in doing things?	0	1	2	3
PHQ.2	Feeling down, depressed or hopeless?	0	1	2	3
PHQ.3	Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
PHQ.4	Feeling tired or having little energy?	0	1	2	3
PHQ.5	Poor appetite or overeating?	0	1	2	3
PHQ.6	Feeling bad about yourself- or that you are a failure or have let yourself or your family down?	0	1	2	3
PHQ.7	Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
PHQ.8	Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving a lot more than usual?	0	1	2	3

**End of Part 1 of the Study**

Thank you very much for taking the time to fill out the online questions. The aim of these questions was to screen participants eligible to take part in part two of this online study. I will email you shortly to discuss next steps. Thank you for your patience.

If you have any questions please email me on [as678@exeter.ac.uk](mailto:as678@exeter.ac.uk)

Best wishes

Agata Sawicka

Principal Researcher

[as678@exeter.ac.uk](mailto:as678@exeter.ac.uk)

## Study 2 Information sheet

**Thank you for completing part 1 of this study. Welcome to part two of the screening questionnaire for the "Study for abuse survivors".**

You will now be asked to complete some questionnaires exploring different emotional responses to child sexual abuse experiences.

What does participation involve?

You will now be invited to complete a few questionnaires exploring emotional responses to child sexual abuse experiences. The study will take approximately 20 minutes.

This study consists of different types of questions. Some of them will ask you about your responses and thoughts following your experience of child sexual abuse or unwanted sexual contact prior to the age of 18. Some of the questions will focus on your current mood and your personality.

### **Do I need to take part?**

The participation in the study is voluntary. The study aims to seek out survivors of child sexual abuse worldwide and the participation is voluntary.

### **Can I save and return later?**

It is better to complete the survey at once, with no breaks. Part two takes about 20 minutes to complete. If you need to save and return, click on 'Resume later' at the bottom of the screen at any point in the study. will be directed to another screen where you will be asked to give yourself a name or pseudonym (it does not have to be your real name) and a password. You can enter your email address optionally too, then your name and password would be sent to you. When you want to continue you can click on 'Load unfinished survey' at the bottom of the screen and what you already completed won't be lost.

### **What if I don't want to carry on with the study?**

All participants have the right to withdraw their data from the study at any point without having to give a reason.

### **What are the possible benefits of taking part?**

There are no direct benefits for you. The questionnaires you fill out will allow the researcher to understand the impact of child sexual abuse on adult survivors and help us refining and extending psychological therapies.

### **What are the disadvantages of taking part in this study?**

The questionnaires might upset you temporarily as they might bring back the memories of your experiences and elicit some feelings in you. The online study will direct you to support groups in your area and provide useful contact numbers in case you decide to seek additional help. If you are concerned at any point it might be helpful to see your GP.

### **What will happen with the results of the research study?**

The data will be stored securely on a server and only the author of this study will have access to the data. The data obtained from your study will be combined with that of other participants to be written up as part of the Doctorate of Clinical Psychology course fulfilment. The data will also be stored securely following the

data collection. The study will be written up to appear in one of the scientific journals. This will be achieved in order to inform other clinicians and scientists who are working to support people affected by traumatic experiences and their families. Any write-up will not mention the participants personally, nor detail their name or any other personal detail. No other identifiable information about you will be published with the results. You can request that a copy of the findings is sent to you when it becomes available.

**Who has reviewed the study?**

The appropriate ethical committees within the University of Exeter approved the research study to ensure the highest ethical standard.

**What to do if there is a problem?**

If you are experiencing any technical problems or have any questions or queries about the study, please email the researcher (the email address is provided below).

**Thank you for your time.**

Agata Sawicka  
 Trainee Clinical Psychologist  
 University of Exeter  
 United Kingdom  
[as678@exeter.ac.uk](mailto:as678@exeter.ac.uk)

**Participant Number**

Please enter the participant number allocated to you by the researcher in the email you received [Blank space].

**Outcome measures**

**PTSD Checklist-Civilian Version (PCL-S)**

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences such as child sexual abuse. Please read each one carefully, put an 'X' in the box to indicate how much you have been bothered by that problem *in the past month*.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts or images of a stressful event from the past?					
2.	Repeated, disturbing dreams of a stressful experience from the past?					
3.	Suddenly acting or feeling as if stressful experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful experience from the past?					
5.	Having physical reactions (e.g. heart pounding, trouble breathing or sweating) when something reminded you of a stressful experience from the past?					
6.	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7.	Avoid activities or situations because they remind you of a stressful experience from the past?					
8.	Trouble remembering important parts of a stressful experience from the past?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being 'super alert' or watchful on guard?					
17.	Feeling 'jumpy' or easily startled?					

## **posttraumatic cognitions inventory (pcti)**

*your name:*

*today's date:*

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each by putting the appropriate number between 1 & 7 in the box to the right of the statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>
<i>totally disagree</i>	<i>disagree very much</i>	<i>disagree slightly</i>	<i>neutral</i>	<i>agree slightly</i>	<i>agree very much</i>	<i>totally agree</i>

1.	the event happened because of the way I acted	
2.	I can't trust that I will do the right thing	
3.	I am a weak person	
4.	I will not be able to control my anger and will do something terrible	
5.	I can't deal with even the slightest upset	
6.	I used to be a happy person but now I am always miserable.	
7.	people can't be trusted	
8.	I have to be on guard all the time	
9.	I feel dead inside	
10.	you can never know who will harm you	
11.	I have to be especially careful because you never know what can happen next	
12.	I am inadequate	
13.	if I think about the event, I will not be able to handle it	
14.	the event happened to me because of the sort of person I am	
15.	my reactions since the event mean that I am going crazy	
16.	I will never be able to feel normal emotions again	
17.	the world is a dangerous place	
18.	somebody else would have stopped the event from happening	
19.	I have permanently changed for the worse	
20.	I feel like an object, not like a person	
21.	somebody else would not have gotten into this situation	
22.	I can't rely on other people	
23.	I feel isolated and set apart from others	
24.	I have no future	
25.	I can't stop bad things from happening to me	
26.	people are not what they seem	
27.	my life has been destroyed by the trauma	
28.	there is something wrong with me as a person	
29.	my reactions since the event show that I am a lousy copper	
30.	there is something about me that made the event happen	
31.	I feel like I don't know myself anymore	
32.	I can't rely on myself	
33.	nothing good can happen to me anymore	

## Disclosure of Trauma Questionnaire (DTQ)

In the following, please indicate to which degree you agree or disagree with each statement.

No.		Not at all (0)	Not very (1)	Partially (2)	Considerably (3)	Very much (4)	Completely (5)
1.	There are several people I have told the story to several times.						
2.	It is important to me to repeatedly talk about what happened and how it happened.						
3.	The more often I talk about the event, the clearer it becomes to me.						
4.	When I talk about my experiences, I try to imagine everything as it was.						
5.	I often describe feelings of fear, shock, humiliation, or of feeling paralyzed.						
6.	I think considerably more of the incident than I talk about it.						
7.	If I tell my friends about the incident, I only shock them.						
8.	I must get the experience clear in my mind.						
9.	I haven't told anybody about the event.						
10.	It is much more important to clarify my feelings in the situation than to describe the incident precisely.						
11.	I feel like I have to talk about the event a lot.						
12.	I only describe the things that happened with keywords.						
13.	My voice often fails when I describe my experiences in full.						
14.	I often describe how helpless I felt in that situation.						
15.	After I talked about the event I always feel exhausted.						
16.	It wouldn't help me any further if I told somebody about the incident.						
17.	I find it difficult to talk to people about the incident.						
18.	I never find the right time to talk about the experiences that I had during the event.						
19.	The more I talk about the incident, the better I can express the feelings I had in that situation.						
20.	I often leave out details in my descriptions of the incident.						
21.	I feel extremely tense when I describe the incident.						
22.	After I have described everything, I feel relieved.						
23.	I find it more comfortable not to talk about the incident.						
24.	I don't want to burden my partner, family or friends by telling them about the incident.						
25.	I find it easy to talk about my experiences.						
26.	I feel compelled to talk about my experiences again and again.						

No.		Not at all (0)	Not very (1)	Partially (2)	Considerably (3)	Very much (4)	Completely (5)
27.	I like to talk about the event as often as possible.						
28.	My family/friends reproach me for only ever talking about the incident.						
29.	It is difficult for me to speak about the incident in detail.						
30.	Describing the event makes me feel very sad.						
31.	When I describe the incident in detail, I feel taken back to the event.						
32.	While describing the incident, my heart starts pounding, I start sweating, or I start to shake.						
33.	I often think about the event, but I don't talk about them very much.						
34.	I haven't told anybody exactly what happened.						



### Open-ended questions

1. What did it mean for your perception of your role as a man/a woman that you experienced child sexual abuse? [Blank space]
2. Did the fact that you are a man/a woman make your recovery more difficult? [Blank space]
3. How did your perception of yourself as a man or a woman change following your experience of child sexual abuse? [Blank space]
4. Do you think it was more difficult for you to recover because you are a man/a woman? If so, why? [Blank space]
5. What do you think the society could do to make recovery from child sexual abuse easier if you are a man/a woman? [Blank space]
6. Did you disclose your traumatic experience to any person, someone you know privately or a professional? [Blank space]
7. What allowed you to disclose your experience or what prevented you from it? [Blank space]

### Debrief information

Thank you very much for taking the time to fill out the online questions. Please take a moment to read the information and after you finished please click on the link below to view a very short video.

The aim of these questions was to explore how people with different personalities process past experiences of child sexual abuse. You will be emailed shortly by the researcher who would like to thank you for your participation.

This study was particularly interested in how men and women differ in their emotional responses to child sexual abuse. I wanted to explore whether men and women differ in their ability to disclose of the traumatic event. I also wanted to explore whether any particular personalities were more likely to seek help, e.g. whether men who are more affected by their experience hold more traditional, masculine norms, which they apply to themselves and others.

**Please take a moment to view the short video. It is password protected. When asked about the password, please type in 'studyvideo'.**

<https://vimeo.com/138466802>

If you are experiencing low mood following this study, please contact your GP. Alternatively, below are some contact numbers and websites and contact numbers, which you might find useful.

**For male and female survivors based in the United Kingdom:**

- **National Association for People Abused in Childhood (NAPAC)** [www.napac.org.uk](http://www.napac.org.uk) (NAPAC helpline (phone line 24/7) 0808 801 0331)
- **Samaritans-** for people in distress <http://www.samaritans.org/> (phone line 24/7) 08457 90 90 90
- **Survivors Trust** [www.thesurvivorstrust.org](http://www.thesurvivorstrust.org)
- **Stop It Now!** [www.stopitnow.org.uk](http://www.stopitnow.org.uk)
- **Survivors UK** (phone line Mon-Thu, restricted hours only) 0845 122 1201
- **Breathing Space** phone line for people in distress based in Scotland (24/7) 0800 838 587
- **Rape and Sexual Abuse Support Centre (RASAC)** for UK survivors of child sexual abuse 0808 802 9999 (phone line of restricted hours only)

**For male survivors based in the United Kingdom:**

- **Survivors UK** [www.survivorsuk.org](http://www.survivorsuk.org)
- **Abused Men in Scotland (AMIS)** phone line of restricted hours 0808 800 0024
- **MPower- Support for Male Survivors of Abuse** (24/7) 0808 808 4321

**For female survivors based in the United Kingdom:**

- **The Rape and Abuse Line (RAL)** line answered by women only (24/7) 0808 800 0123

**For male and female survivors based in the United States of America:**

- **After Silence** [www.aftersilence.org](http://www.aftersilence.org)
- **Pandora's Project** [www.pandys.org](http://www.pandys.org)
- **Help for Adult Victims of Child Abuse (HAVOCA)** [www.havoca.org](http://www.havoca.org)
- **National Sexual Assault Hotline** for child sexual abuse survivors 1.800.656.HOPE (24/7)
- **Rape Abuse Incest National Network (RAINN)** 24/7 800 656 4673 or HOPE

**For male and female survivors based in Ireland:**

- **Rape Crisis Network Ireland** [www.rcni.ie](http://www.rcni.ie)
- **Stop It Now!** [www.stopitnow.org.uk](http://www.stopitnow.org.uk)
- **Rape Crisis and Sexual Abuse Centre** for sexual assault and child sexual abuse survivors 028 9032 9002
- **National Office for Abuse Victims** for survivors of child sexual abuse 1800 25 25 24

**For male and female survivors based in Canada:**

- **Canadian Centre for Male Survivors of Child Sexual Abuse (cc4ms)** [www.cc4ms.ca](http://www.cc4ms.ca)
- **Canada Abuse Directory for survivors of child abuse** 1 800 363 9010 24/7

**For male and female survivors based in Australia:**

- **Living well** [www.livingwell.org.au](http://www.livingwell.org.au)
- **Survivors and Mates Support Network (SAMSN)** [www.samsn.co.au](http://www.samsn.co.au)
- **Adults Surviving Child Abuse (ASCA)** [www.asca.org.au](http://www.asca.org.au)
- **1800 RESPECT** National helpline for sexual assault, family and domestic violence survivors (24/7) 1800 737 732
- **Adults Surviving Child Abuse (ASCA)** 1300 657 380

**For male and female survivors based in New Zealand:**

- **Adult Survivors of Child Sexual Abuse** [www.rapeandabuse.co.nz](http://www.rapeandabuse.co.nz)
- **National Association of Adult Survivors of Child Abuse (NAASCA)** Crisis Line 0800 883 300

**For male survivors based in New Zealand:**

- **Male Survivors of Sexual Abuse** [www.survivor.org.nz](http://www.survivor.org.nz)
- **Male Survivors of Sexual Abuse (MSSAT)** 03 377 6747

If you have any questions please email me on [as678@exeter.ac.uk](mailto:as678@exeter.ac.uk).

Best wishes

Agata Sawicka,

Principal Researcher.

## Appendix F: E-mail to Excluded Participants

Dear Participant,

You are receiving this e-mail because you recently participated in part 1 of a research study for survivors of child sexual abuse. In the study you completed a brief set of questions. Thank you very much for your participation and taking your time to fill out the online questions. The aim of these questions was to check your eligibility to participate in a further online study.

I am sorry that at this time you are not eligible to take part in the other part of this study as we have very strict criteria on who can participate. This is because the content of the online study can be stressful for some individuals. Your answers to one or more of the questions indicated that it would not be suitable for you to take part in the other online study at this time. Thank you for taking time to fill out this online questionnaire.

The reason I am contacting you again is because on one of the questionnaires, the depression severity measure, you scored above a particular threshold score, indicating that you may currently be experiencing high levels of symptoms of depression. The questionnaire does not unequivocally diagnose depression; instead it just gives an indication that you are currently experiencing a high number of specific thoughts and feelings, which can be a sign of depression.

We understand that you may not be interested in receiving this feedback and any information about depression or that you may already be managing or seeking help for your feelings or difficulties. Alternatively, what you reported in the questionnaires may have resolved itself since you completed the questionnaires, or the questionnaires may have exaggerated how distressed you were feeling (which can sometimes happen, especially during stressful time periods, since questionnaires only have limited response options). If any of the above is the case, please ***feel free to disregard this e-mail.***

However, ***if you are experiencing some difficulties with your mood and are not currently receiving help and/or feel you may benefit from some support for these feelings***, or if you are simply interested in receiving some more information about depression, ***you may find the following information helpful.*** If you are experiencing depression or thoughts of being better off dead, and you are currently not receiving any treatment, it is strongly recommended that you make an appointment with your GP to talk about how you are feeling and to consider treatment options. ***Your GP is there to support you*** and can either directly provide treatment (e.g., by prescribing medication, if that is appropriate and your choice), or can access other treatments (such as psychological therapy) for you.

If you want ***immediate support or advice for any difficulties***, we list a ***number of support networks and websites in different countries***, which you might find useful depending on your location:

**For participants based in the United Kingdom:**

**Depression Alliance**

Depression Alliance is a charity which aims to assist people who are affected by depression. Depression Alliance offer information, a range of publications, self-help and support groups for people with depression.

**Telephone (to request an information pack):** 0845 123 23 20

**E-mail:** [information@depressionalliance.org](mailto:information@depressionalliance.org)

**Website:** <http://www.depressionalliance.org>

**Address:** Depression Alliance, 20 Great Dover Street, London, SE1 4LX

### **SANeline**

SANeline is a national out-of-hours telephone helpline, offering emotional support and information for people affected by mental health problems. They also offer e-mail support through SANemail, their e-mail service.

**Telephone (6pm – 11pm, daily):** 0845 767 8000

**E-mail:** visit <http://www.sane.org.uk/SANemail>

**Website:** <http://www.sane.org.uk/SANeline>

**Address:** 1<sup>st</sup> Floor Cityside House, 40 Adler Street, London E1 1EE

### **For participants based in the United Kingdom and Ireland:**

#### **Samaritans**

Samaritans provides confidential emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair. Samaritans are there if you're worried about something, feel upset or confused, or just want to talk to someone.

**Telephone (24 hours):** 08457 90 90 90

**E-mail:** [jo@samaritans.org](mailto:jo@samaritans.org)

**Website:** <http://www.samaritans.org>

**Address:** Chris, P.O. Box 9090, Stirling, FK8 2SA

### **For participants based in the United States of America:**

#### **The Samaritans USA**

The organisation aims at helping people in distress and preventing suicide.

24-hour crisis hotline: (212) 673-3000 when you need someone to talk to 24/7.

Samaritans website: <http://samaritansnyc.org/24-hour-crisis-hotline/>

#### **Disaster Distress Helpline**

Substance Abuse and Mental Health Administration (SAMHSA)'s helpline provides crisis counselling and support to people experiencing emotional distress related to natural or human-caused disasters. It is confidential, multilingual and available to residents of the USA.

Telephone number: **1-800-985-5990**

Text: **TALKWithUs to 66746**

**Website:** <http://www.samhsa.gov/find-help/disaster-distress-helpline>

### **For participants based in Canada:**

#### **Crisis Support Centre**

Crisis Support Centre offers a number of interventions to people in distress based in Canada. These include:

**24-Hour Distress Line**

**Seniors' Abuse Helpline**

**Online Crisis Chat**

**Suicide Bereavement Support Services**

**Suicide Caregiver Support Services**

**Crisis Support Centre**

**c/o The Support Network**

400 - 10025 106 Street

Edmonton, AB T5J 1G4 Canada

Phone: (780) 482-0198

Fax: (780) 488-1495

**admin@crisissupportcentre.com**

**24-Hour Distress Line**

(780) 482-HELP (4357)

**Online Crisis Chat**

**Seniors' Abuse Helpline**

(780) 454-8888

**Canadian Mental Health Association**

The CMHA helps those in crisis and emergency situations. It offers a number of helplines and contact numbers such as:

**Mental Health Helpline**, 1-866-531-2600

**Drug and Alcohol Helpline**, 1-800-565-8603

**Ontario Problem Gambling Helpline**, 1-888-230-3505

**Website:** <https://www.cmha.ca/>

**For participants based in Australia:**

**Lifeline**

Lifeline offers Crisis Support and help to those experiencing personal crisis.

Website: <https://www.lifeline.org.au/>

Phone number 13 11 14

If life is in danger call 000

**For participants based in New Zealand:**

**Mental Health Foundation of New Zealand**

The website lists numbers of services available in the country for people affected by distress and in crisis.

National helplines

**Lifeline** – 0800 543 354 or (09) 5222 999 within Auckland

**Suicide Crisis Helpline** – 0508 828 865 (0508 TAUTOKO)

**Healthline** – 0800 611 116

**Samaritans – 0800 726 666 (for callers from the Lower North Island, Christchurch and West Coast) or 0800 211 211 or (04) 473 9739 for callers from all other regions.**

**Chinese Lifeline – 0800 888 880 (for people who speak Mandarin or Cantonese)**

**Website: <http://www.mentalhealth.org.nz/get-help/in-crisis/helplines/>**

If you have any specific questions or concerns, please contact me at [as678@exeter.ac.uk](mailto:as678@exeter.ac.uk), and I or my supervisor, who is a qualified and experienced clinical psychologist, will provide further advice and guidance.

Kind regards,

Agata Sawicka

Trainee Clinical Psychologist  
University of Exeter

## Appendix G: Steps of Thematic Analysis

Number	Step	Description
1	Familiarising with data	NVIVO 11 software for qualitative data analysis was used. Grouping the responses into those corresponding to questions exploring disclosure or gender role perceptions.
2	Generating initial codes	Re-reading the responses and generating main structural codes and associated sub-codes.
3	Searching for themes	Interpreting by searching for patterns in the data and attempting to reduce the volume of detail whilst maintaining complexity.
4	Reviewing themes	Re-reading the data grouped into different themes and assessing its fitness. Coding and uncoding processes.
5	Defining and naming themes	Drawing together the emerging themes and exploring how they relate to each other. Investigating how themes relate to existing literature.
6	Producing the report	Measuring recurrence by assessing frequencies and co-occurrence. Re-labelling and re-configuring of themes. Graphically displaying relationships between themes.



## Appendix H: Quotations for Each Theme

Theme	Quotations
<b>1. Barriers to disclosure</b>	
1.1 Invalidating experiences of disclosure	<p>P222 "The reactions of other people when told seemed more extreme and threatening than the experience ..."</p> <p>P234 "She told me god had a special place in hell for little girls who played with themselves to please their father ..."</p> <p>P101 "after I reported ... my whole family abandoned me ... it was easier to pretend that it never happened than dealing with such a difficult and challenging situation ..."</p> <p>P1 "after telling my mum about the initial abuse, she told me my dad was just being curious"</p> <p>P187 "people being minimising, disregarding, negating, defensive, wanting to move on"</p> <p>P11 "and this feeling that talking about it will cause emotional distress in the listener"</p>
1.2 Delaying disclosure	<p>P14 "I feel very guilty that I let it go on for so long; I didn't tell until I was an adult ..."</p> <p>P194 "I felt so ashamed and guilty it took me over 20 years to seek help ..."</p> <p>P33 "It took me seven years after it finished to disclose to a counsellor ... I wrote it down on a piece of paper and put it in an envelope and every week when we came to the session I would bring it till I got enough courage to let them open it ..."</p> <p>P138 "others non-verbally told me that they really didn't want to know ..."</p> <p>P174 "no one heard what I dared told, so I didn't say any more ..."</p> <p>P1 "I kept it hidden for 20 years trying to have a proper relationship with my parents"</p> <p>P140 "it was my mum's boyfriend that abused my sister and I, and my mum was happy with this man, the happiest I had seen her in a long time, and I didn't want to ruin that for her ..."</p>
<b>2. Allowing disclosure</b>	
2.1 Context of breakdown or crisis	<p>P1 "...I was nearly ready to kill myself as I couldn't live with myself any longer (...) I got to the point I was so sad in my mind and body I had to tell or I would die from implosion, my whole body ached from the secret lurking in my mind, it had took great effort to keep the vault door shut on my past, and every year I got weaker..."</p> <p>P159 "...My first disclosure was to a wife after 25 years of marriage which was failing at the time I was rapidly heading for crisis (...) the realization that I was in crisis (...) the loss of family or friends as I got progressively crazier was a deal breaker for me"</p> <p>P49 "...Being a mother of a young child (...) when learning I was a Survivor was exceptionally difficult as my emotions regressed to that of the child age 8&amp;9..."</p> <p>P155 "...I started doing things that made no sense, my oldest child was the age I was when the abuse happened to me, and I ended up in a hospital because I was suicidal..."</p> <p>P10 "...I began having flashbacks and became aware that my behaviour and actions were dictated by my trauma..."</p> <p>P23 "...I had to. My life was falling apart. I needed to be there to raise my son who was 4 (...) my drug addiction had spiralled out of control and then one day the box that contained all those memories and kept them separate from the rest of me finally opened."</p> <p>P111 "...my depression and anxiety were really bad at those points and I felt they deserved an explanation for my behaviour..."</p>
2.2 Supportive others	<p>P187 "people believing my experience as it unfolded, people giving space for what was coming up to be expressed, and not interpreting or getting in the way or minimising or over-reacting ..."</p> <p>P54 "I believed that I could be vulnerable to them and knew that they would hold my story in confidence and support me as I continued to heal ..."</p> <p>P203 "when the counsellor told me 'it's not your fault', that day changed my life ... I started healing ..."</p> <p>P94 "I recovered so easily as I was encouraged, appreciated and loved and never judged ..."</p>

Theme	Quotations
<b>4. CSA and female gender perception</b>	
4.1 Women as sexual objects	<p>P134 "as a youth I desperately wanted to be loved and confused sex and male validation with approval and love ..."</p> <p>P44 "I have also connected my self-worth to my sexuality ... I have the distorted belief that, in order to matter to a man, he must perceive me as physically attractive"</p> <p>P154 "as a woman ... I feel like I should have sex to please a man ..."</p> <p>P155 "for years I didn't know how to say no to sex, even if I didn't want it ..."</p> <p>P168 "as a woman I believed I was here to let men have sex with me ..."</p> <p>P173 "That it was normal for women to expect abuse from men ..."</p> <p>P139 "women are abused, suppressed, violated, devalued, and denigrated at every turn, but this is not spoken about ..."</p> <p>P78 "In the eyes of my mother I became a slut and the boy was just a boy. I had to be a good girl and shut my mouth or I would be shamed ..."</p>
4.2 Worthlessness	<p>P62 "I did not deserve to be treated respectfully ... I try to be invisible as often as possible ... I always felt like I was bad or not worthy ..."</p> <p>P16 "I realised they only saw me as an object, or some form of vermin ... they didn't see a human ... I realised that I'd taken this 'inhuman' identity on for my whole life"</p> <p>P189 "I felt unclean, not a good person, contaminated"</p>
<b>4. CSA &amp; male gender perception</b>	
4.1 Inadequate as men	<p>P220 "Men are supposed to be defenders and protectors. I couldn't even defend myself – how will I ever be able to protect anyone else?"</p> <p>P232 "It enraged me as those things don't happen to real men. It made me feel less of a man ... my sense of being a real man was damaged ..."</p>
4.2 Men can't be vulnerable	<p>P182 "As a child it was dangerous to show emotion and even now I find it hard to show emotions, it was difficult to seek help through counselling as it's not the done thing for a man ..."</p> <p>P220 "as a man there are added obstacles to recovery. I ... have to deal with my own emotions ... and the stigma connected to it ... as a man, talking about the experience puts the spotlight on me and not the problem ..."</p> <p>P7 "society does not accept men that are hurting ... I wish that society could allow men to express themselves in ways that don't involve violence and hurting others ..."</p>

## Appendix I: Journal of Traumatic Stress – Authors Guidelines

### Scope of the Journal

The *Journal of Traumatic Stress* is the official publication of the International Society for Traumatic Stress Studies of peer-reviewed original papers on biopsychosocial aspects of traumatic stress from authors around the world. Papers present empirical research and can focus on diagnosis, assessment, treatment, prevention, education and training, cultural aspects of traumatic stress, and legal and policy concerns. Meta-analyses are also published. It serves as a primary reference for professionals who study and treat a broad diversity of people exposed to events of traumatic stress with life threat in some form, such as war, disaster, accident, violence or abuse, or hostage-taking across all nations and populations.

### Submitting Manuscripts

The *Journal of Traumatic Stress* accepts submission of manuscripts online at <http://mc.manuscriptcentral.com/jots>

Three paper formats are accepted. All word counts should include references, tables, and figures. *Regular articles* (no longer than 6,000 words) are theoretical articles, full research studies, and reviews. In special circumstances, the editors will consider longer manuscripts (up to 7,500 words) that describe complex studies. Authors are requested to seek special consideration prior to submitting manuscripts longer than 6,000 words. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

### Presentation of the Manuscript

#### Format

The *Journal* follows the style recommendations of the 2010 *Publication Manual of the American Psychological Association* (APA; 6th). Files must be formatted using letter or A4 page size, 1 inch (2.54 cm) margins on all sides, Times New Roman 12 point font, and double-spacing for text, tables, figures, and references.

#### Title Page

It should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) byline and institutional affiliation, and author note (see pp. 23-25 of the APA manual). An abstract no longer than 200 words follows the title page on a separate page.

#### Tables and Figures

They should be formatted in APA style. Count each full-page table or figure as 200 words and each half-page table or figure as 100 words. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table and figure should begin on a separate page. Figures (photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred

to by number in the text. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Figures should be in Word, TIFF, or EPS format. Footnotes should be used sparingly.

## References

Format the reference list using APA style: (a) begin on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author.

### *Journal Article*

Kraemer, H.C. (2009). Events per person-time (incidence rate): A misleading statistic? *Statistics in Medicine*, 28, 1028–1039. doi: 10.1002/sim.3525

### *Book*

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

### *Book Chapter*

Meehl, P. E. (2006). The power of quantitative thinking. In N.G. Waller, L.J. Yonce, W.M. Grove, D. Faust, & M.F. Lenzenweger (Eds.), *A Paul Meehl reader: Essays on the practice of scientific psychology* (pp. 433–444). Mahwah, NJ: Erlbaum.

## Blind Review

The *Journal* uses a policy of unmasked review. Author identities are known to reviewers; reviewer identities are not known to authors. During the submission process, authors may request that specific individuals not be selected as reviewers; the names of preferred reviewers also may be provided. Authors may request blind review by contacting jots@ucsf.edu prior to submission in order to provide justification and obtain further instructions.

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## Open Access Option

The *Journal of Traumatic Stress* accepts articles for Open Access publication. Authors of accepted peer-reviewed articles have the choice to pay a fee in order for their published article to be made open access. The Online Open fee is fixed

at US\$3000 for most journals. Please see below for a list of journals with different rates. Any additional standard publication charges will also apply, such as for colour images or supplementary datasets. The publication fee is charged on acceptance of the article and should be paid within 30 days by credit card by the author, funding agency, or institution. Payment must be received in full for the article to be published Online Open.

All Online Open articles are treated in the same way as any other article. They go through the journal's standard peer review process and will be accepted or rejected based on their own merit. The Online Open option is offered only to those authors whose articles have been accepted for publication, and only at the point when the article is accepted, to ensure that the Online Open option has no influence on the peer review and acceptance process.

## **Appendix J: Dissemination Statement**

The results of this study will be disseminated to interested parties through feedback, journal publication and presentation.

### **Dissemination to participants**

The findings of the study will be disseminated to participants, who all provided their email addresses in order to take part. A short summary of the findings will be sent via email. Participants will be thanked for their participation and courage to speak about their difficult experiences.

### **Journal Publication**

It is expected that the Literature Review will be submitted for publication with the Clinical Psychology Review (impact factor 5.88) and the Empirical Paper will be submitted for publication with the Journal of Traumatic Stress (impact factor 2.71).

### **Presentation**

In June 2016, my research findings will be presented to an academic audience, for peer review, as part of the Doctorate in Clinical Psychology at the University of Exeter.